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HEALTH AND MANAGING SOCIAL RISK: YOUNG SUMMER WORKERS' PERCEPTIONS

by

SHEILA MARIE GALLAGHER

A thesis

Submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY

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DEDICATION

This work is dedicated to Joanne Gildea Jaeger, who cares deeply first and last and who introduced me to the profession of nursing.

ABSTRACT

The purpose of this study was to understand the perceptions of the Shadow Population (SP) about their personal health issues and access to health services and relevant resources. The SP are a group of transient young adults who come to work in Jasper National Park's hospitality and tourism industry but who remain in Jasper longer than one tourist season. Also identified was the Adolescent Shadow Population (ASP) who come to live and work in Jasper for one tourist season per year. The ASP were a primary focus in this study.

A qualitative, inductive approach was taken in this inquiry because neither the SP nor the ASP had been studied previously. Dimensional Analysis (DA), an evolved form of grounded theory developed by Schatzman (1991), was used as an analytic strategy.

Findings indicated that managing perceived social risks associated with health conditions was the prominent dimension of the ASP's endeavor to deal with personal health issues. Specifically, strategies employed by the ASP and SP to deal with personal health conditions, included Avoiding Perceived Social Risk, Minimizing Perceived Social Risk, and Embracing Perceived Social Risk. Social risks were defined as risks to peer relationships and to employment of ASP and SP members. An associated type of risk, less dominant in the perceptions of the SP, is the health risk for the SP members and their peers that arises from failure to treat some health conditions.

Differentiating the elements that influence selection of strategies into dimensions within the DA matrix (Context, Attributes, Conditions, Action and Consequence) was the heart of this analysis. The convergence of the first three of three dimensions lead to the selection of a management strategy by SP members (Action) and subsequently, to varied Consequences.

Issues categorized in the dimension labeled Context are given for all SP members (e.g. their age, short-term residence, and low paying jobs). Attributes describe the nature of the presenting health condition. Conditions facilitate or block actions (e. g. fear of confidentiality and anonymity transgressions in a small town and perceived barriers, both social and logistical, to accessing local formal health services).

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TABLE OF CONTENTS

CHAPTER PAGE

1. INTRODUCTION 1
   - Statement of the Problem 1
   - Rationale for the Study 2
     - Paucity of Data on the SP. 2
     - Health Risks of a Vulnerable SP. 3
     - Primary Health Care as a Guiding Perspective 3
     - Nursing and PHC 5
   - Purpose Statement and Research Questions 6
2. REVIEW OF LITERATURE 8
   - Adolescents and Health 8
   - Vulnerability and High Risk Groups 9
   - Transitions 12
   - Accessing health services 13
3. METHODOLOGY 18
   - The Purpose and Overview 18
   - In the Tradition of Chicago's Action Scheme: Dimensional Analysis 21
     - Explanation, Analysis, Discovery and Pragmatism 23
     - Dimensional Analysis and the Shadow Population Study 24
   - General Design for Data Generation 25
     - The Pilot Focus Group 26

Sample Selection 27
Inclusion and Exclusion Criteria 28
Recruitment of the SP: Two Phases....................32
Data Collection and Analysis Overview 41
Rigor and Method....................47
Ethics....................50
Concluding Thoughts 50
4. FINDINGS....................52
Sample....................52
Categories of Informants....................52
Two Study Segments 53
Sample in the Data Gathering Segment....................54
Sample in the Validation Segment....................55
Characteristics of the Shadow Population Respondents 56
Characteristics of the Non Shadow Population Respondents....................57
Characteristics of Other Respondents 58
Subgroups of the Shadow Population in Jasper....................58
Identifying the Boundary: The Discovery of the Adolescent Shadow Population (ASP) 58
Other Shadowy Subgroups....................60
Shoulder Season: From Shadow to Seasonal....................61
Jasper Park Lodge: A World Unto Itself....................62
Temporal Influence on ASP 63

Perceived Social Risks 64
- Strategies to Control Perceived Social Risk 68
- Dimensions Contributing to SP Strategy Selection: Attributes 69
- Stigmatizing Conditions 69
- Minor Conditions 74
- Unquestionable, Non-stigmatizing Conditions. 76

Dimensions Contributing to SP Strategies Selection: Conditions 77
- Perceived Threats to Confidentiality and Anonymity 77
- Perceived Barriers to Accessing Local Formal Health Services 80

Risk Managing Strategies 85
- Strategies to Negate Perceived Social Risk 85
- Strategies to Minimize Perceived Social Risk 98
- Strategies to Engage Perceived Social Risk 103

Consequences Associated with Different Selection of Strategies 108

5. DISCUSSION 112

ASP and SP Strategy Selection 114
- Developmental Issues and Selection of Social Risk Management Strategies 114
- Parameters of Adolescent Development 116
- Social Risk Control Strategies: Cognitive and Psychosocial Development Underpinning 117
- Adolescent Developmental Tasks 120
- Adolescents and Risks 122

Adolescents and Risk-taking........123
ASP/ The strategies........126
High Stakes Risks: Stigmatizing Health Conditions........127
Adolescents and Stigma........128
Beyond Goffman........130
STDs, AIDS, and Stigma........131
Adolescents, Action, and Sexual Conditions........132
Taxonomy and Catastrophe : The ASP Perception of AIDS........133
Perceived Risk Management Strategy Selection........134
Models of Health Behavior........135
Socioeconomic Status of the SP........139
Concluding Thoughts........140
Limitations........141
6. CONCLUSION........143
Implications for Nursing Practice........143
Issues for Future Research........146
Concluding Remarks........148
REFERENCES........150
APPENDIX A: GUIDING QUESTIONS FOR THE ASP/SP INTERVIEWS........163
APPENDIX B: GUIDING QUESTIONS FOR NSP AND 'OTHER' INTERVIEWS........166

APPENDIX C: RESEARCH CONSENT FORM FOR INTERVIEWS WITH SHADOW POPULATION (SP), NON-SHADOW POPULATION, AND OTHER RESPONDENTS..................169

APPENDIX D: BIOGRAPHICAL INFORMATION FORM FOR ASP AND SP RESPONDENTS..................173

APPENDIX E: BIOGRAPHICAL INFORMATION FORM FOR NSP AND OTHER' RESPONDENTS..................177

APPENDIX F: RECRUITMENT FLYER..................179

APPENDIX G: DIMENSIONAL ANALYSIS MATRICES FOR INDIVIDUAL STRATEGIES 181

LIST OF TABLES

TABLE PAGE

1. Dimensional Analysis Matrix 47
2. Distribution Among Three Groups of Respondents in Data Gathering Section.. 54
3. Overview of Analysis.. 65
4. Dimensions Contributing to SP Strategies Selection.. 67
5. Categories of Strategies to Control Perceived Social Risks.. 68
6. Associated Consequences in Terms of Type of Risk.. 109
7. Perspective: Controlling Perceived Social Risks.. 110

1. Introduction

Statement of the Problem

The population central to this study is Jasper National Park's (JNP) Shadow Population. Shadow Population (SP) is the informal name given by local health and social service workers to the young adults who come to JNP to work seasonally in service jobs that support the tourism and hospitality industry. The SP is considered a vulnerable group by health and social service professionals in Jasper. Professionals' perceptions of the SP as vulnerable are based on observations of the SP's poor health practices; unhealthy lifestyle; limited integration into the community of Jasper; and their low paying, low status jobs (personal communication, K. Waxer; personal communication J. Konklin, July 28, 1994).

The SP became known to this researcher during a focus group held in 1994 as part of the work of a large interdisciplinary and intersectoral research team preparing a proposal to the Tri-Council Secretariat for Eco-Research. The Tri-Council Secretariat was a federal research program that combined the forces of three major Canadian funding bodies: Social Sciences and Humanities Research Council (SSHRC), National Science and Engineering Council (NSERC) and Medical Research Council (MRC). The mandate of the Tri-Council Secretariat was to support interdisciplinary ecological research. This researcher conducted the exploratory focus group with local health, social service and Parks Canada personnel on the health of Jasper's community. During this focus group, three segments of Jasper's (human) community were described: permanent residents, transient residents (the SP) and tourists. In this way, the SP and their vulnerable nature were identified and the opportunity for further study of the SP became clear.

Rationale for the Study

Paucity of data on the SP.

The existence of a SP is not unique to Jasper. Other centers of the tourist and hospitality industry in North America have similar human resource needs and, in all likelihood, respective Shadow Populations. Review of the health and social science literature did not reveal data on these groups, however.

The SP in Jasper has received no previous systematic study, and preliminary investigations with members of local health and social service community have revealed an alarming paucity of data or records on the SP. This apparent tendency of the SP to slip between the cracks of bureaucratic data gathering is the basis for the name Shadow Population. Because of the transient nature of the group, they elude the inclusion criteria for census data and other statistical catch nets. Investigations with the Jasper Health Unit produced no discrete data pertaining to the SP. Health Unit personnel suggested that data on the SP may be tracked by the local Family and Community Social Services (FCSS) (personal communication, B. Bartley, past CEO Jasper Health Unit, May 19, 1995). Inquiries with FCSS on available data pertaining to the SP were fruitless. The FCSS Director informed me that only anecdotal data is kept on the SP by FCSS (personal communication, K. Waxer, Jasper FCSS, May 20, 1995).

Health risks of a vulnerable SP.

There are many health risks facing the SP including, potentially, a compromised ability to access health services and resources. Preliminary investigations suggest that the often newly independent SP members indulge in alcohol and drug abuse, practice unsafe sex, suffer from loneliness, and lack social support. It was reported that some members of the SP tend not to use the formal health or social services available in Jasper. When these services are accessed by the SP, it is frequently late in the course of the precipitating illness, injury, or crisis (personal communication, K. Waxer; personal communication, J. Konklin, July 28, 1994). Members of the SP present in the Jasper local emergency room suffering from drug overdoses precipitated by loneliness and broken hearts from failed romances (personal communication, D. Morrow, May 31, 1995). This pattern could indicate inadequate coping skills and compromised ability to access health and social services appropriately. The need to discover more information about this vulnerable group became clearer with these insights.

Primary Health Care as a Guiding Perspective

This study was directed by a commitment to the constructs of Primary Health Care (PHC). PHC is a guiding perspective for health service provision first espoused by the World Health Organization (WHO) at the 1978 Alma Ata International Conference on Primary Health Care (WHO, 1978).

PHC is defined as:

> essential health care based on practical scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process. (WHO, 1978, p. 429)

Commonly, five discrete principles of PHC are extrapolated from this definition: health promotion, appropriate technology, accessibility to services, public participation and intersectoral collaboration.

The WHO's 1985 specific mandate for PHC services to focus on high risk and vulnerable populations supports PHC as an appropriate perspective for the provision of health services to populations such as the SP. Additionally, several of the discrete PHC principles are pertinent to the SP: access to services, public participation and health promotion. In light of both the SP's health risks and risk taking behaviors as perceived by members of Jasper's health and social service community, a deeper understanding of the SP's patterns of accessing health services and related resources is warranted. Additionally, the SP are not known to participate in discussions or provide feedback about local services. In this way, SP appear to lack the will, understanding or ability to pursue the principle of public participation in the health services available to them in Jasper. As adolescents and young adults, most SP maintain relatively good physical health. With such a population, health promotion, especially self care skills remain an important area for investigation. It is important, therefore, that this research be undertaken to provide baseline information about the SP and some of their health-related issues.

Vulnerable and high risk populations include the poor, minorities, women, children, the elderly, any person experiencing a life transition, and persons experiencing decreased power in their social environment. The determinants of health particular to these groups predict a negative bias for their health. Factors contributing to the compromised health potential for vulnerable groups such as the SP warrant investigation.

Nursing and PHC

Nursing's role in the implementation of PHC has been supported by an impressive list of national and international statements including Health for all Canadians: A call for health care reform (Canadian Nurses Association, 1988), The role of nursing and midwifery personnel in the strategy for health for all (WHO, 1989); Nursing and primary health care: A unified force (International Council of Nurses, 1988); Alma Ata reaffirmed at Riga: A statement of renewal and strengthened commitment to health for all by the year 2000 and beyond (WHO, 1988); Nurses lead the way (Mahler, 1985); Nursing in support of the goal health for all by the year 2000 (WHO, 1982). This professional mandate strengthens the selection of the PHC perspective as a guiding structure for this nursing research study.

Purpose Statement and Research Questions

The purpose of this study was to understand perceptions of the SP about their personal health issues, perceptions of determinants of health and access to health services and related resources. The specific research question was: How do members of the SP perceive their personal health issues, access to health services, and access to relevant resources? Personal health issues included health or illness experiences specific to the SP respondents as well as steps taken to remedy these situations during their present or past period in Jasper. Access to health services issues included SP perceptions and stories concerning the process of seeking formal health services in Jasper. Included in this were both positive stories and discussions about logistical barriers to services (e.g. geographic location of services, hours of operations, etc.); social barriers (e. g. anonymity and confidentiality issues); the complexities of addressing health conditions while living and working in a small town, etc. Relevant resources included non formal services (e. g. self care, pharmacy, health food stores, etc.) accessed by SP respondents or their friends to address health conditions

Initially a broader focus was proposed that included SP perceptions about determinants of health and the interrelationships of environment and health. As the study unfolded, it was evident that these issues were not perceived as salient to SP members. When asked to respond to questions regarding meaning of common determinants of health to their own experience, most respondents were unable to reply. Responses to questions regarding the interrelationships of environment and health were similarly sketchy. Understanding the perceptions of the SP about their personal health issues and access to health services and relevant resources emerged as the dominant focus.

Although no literature could be identified that is specific to the SP, a review of literature pertinent to the context of SP perceptions of and access to health related services is presented in Chapter 2. Other topics to follow include a review of dimensional analysis as an analytic strategy and highlights from operationalizing this study, in Chapter 3; the presentation of findings and generated theoretical construct, in Chapter 4; a discussion of study findings in Chapter 5; and a discussion of the study's limitations and implications in Chapter 6, the concluding chapter.

2. Review of Literature

Literature on Jasper's Shadow Population or any other group of young adults working in the seasonal tourism and hospitality industry has not been found. For this reason, several foundational areas of literature were explored that are relevant to the conduct of this study with Jasper's Shadow Population. Areas of literature in the following review include adolescents and health, vulnerability and high risk groups, the concept of transitions, and issues related to accessing health care services.

Adolescents and Health

A brief view of adolescent health begins the current chapter, although this topic is covered in depth later. Health is a broad and complex topic that defies discussion in brief form. For the present purpose, a brief account will be undertaken. Generally, adolescents are a physically healthy population (Friedman, 1989). Millstein and Litt (1990) draw attention to the contrast between the morbidity and mortality factors of adolescents and those of children and adults: "In contrast to mortality among children and adults, adolescent mortality primarily arises not from disease but from preventable social, environmental, and behavioral factors. Behavioral factors also rank high among causes of morbidity in adolescents" (p. 433). Sells and Blum (1996a) reported a shift in the trend of adolescent morbidity and mortality in the US during the past decade with a decrease in accidents, motor vehicle accidents, illicit substance use, and some STDs while noting an increase in teenage homicide and increases in both risk-taking behaviors and severity of poverty for this group. These authors also cite violence, suicide, and pregnancy as consistent issues of concern for adolescents.

Adolescents' concepts of health and illness roughly correspond with their level of cognitive development with an increasing capacity to incorporate abstract causative factors of health and illness with age (Burbach & Peterson, 1986; Eiser, 1985; Radius, Dillman, Becker, Rosenstock and Horvath, 1980). Rosenbaum and Carty (1996) similarly found that Canadian adolescents held abstract perceptions of health that included "well-being, absence of illness, being fit, dealing with problems and taking responsibility" (p. 741).

Vulnerability and High Risk Groups

Issues related to the health of vulnerable and high risk populations cross nursing and other health disciplines (de la Cuesta, 1991; Iscoe & Harris, 1984; Labonte, 1993; McKnight, 1985; Nelson, 1994; Registered Nurses Association of British Columbia, 1992; Rose & Killen, 1983; Sebastian, 1992; Stewart, 1990; Thomas & Morgen, 1991; Weil, 1989; WHO, 1985; Williams, 1990; Wilson & Simson, 1991). Vulnerable groups have been identified as the poor (Nelson, 1994; Williams, 1990); minorities (Weil, 1989); women, children and the elderly (WHO, 1985); any person experiencing a life transition (Rose & Killen, 1983); and persons experiencing decreased power in their social environment (Labonte, 1993; Sebastian, 1992). Common threads that run through this literature include the propensity of vulnerable and high risk groups to be more susceptible to "poorer health status, health behaviors, health knowledge and health attitudes... because basic prerequisites for health are absent" (Stewart, 1990, p. 454).

Basic prerequisites of health or health determinants have been identified as influential factors in the health status of individuals and aggregates National Forum on Health, 1996; Evans, Barer & Marmor, 1994; Federal, Provincial and Territorial Advisory Committee on Population Health, 1994; Mustard & Frank, 1991). Evans, Barer & Marmor (1994) distill this notion into the question "Why are some people healthy and others not?" (p. ix). The answer to this question lies in the spectrum of challenges within an individual or aggregate's social, economic and physical environment. These challenges and one's ability to address, change, preempt or cope with them determine health. Individuals or aggregates with unfulfilled, limited or compromised ability to resolve these challenges and achieve or maintain their health are considered are considered high risk or vulnerable in this work.

Groups at high risk for health problems are a concern to all health care providers. The profession of nursing has demonstrated particular interest in the provision of health services to such groups (Sebastian, 1992). Historically, the role of nursing with vulnerable groups has been clear. Community/public health nursing has addressed the needs of vulnerable and high risk groups on an individual and broad, community basis since the nineteenth century when this branch of nursing was labeled "District Nursing" by Florence Nightingale (Nightingale, 1991, p. 6).

This study on the SP is an opportunity to understand the perceptions of a contemporary vulnerable group regarding their personal health issues and access to services and related resources. It is noteworthy that while previously unstudied, the SP is but one of many contemporary vulnerable groups of youth or young adults. Among the literature discussing these other contemporary vulnerable groups of youth, Vissing and Diament's 1997 work on high school students and housing distress makes a useful differentiation between the actual state of being homeless and the more inclusive state of "housing distress" (p. 31) in which individuals "at risk of homelessness" (p. 31) are identified. While this distinction between an actual state and potential state of vulnerability is not uniformly used in other literature, it is a useful and practical differentiation to invoke. From a perspective of policy formation, such a differentiation in terminology would benefit vulnerable groups by acknowledging vulnerability as more of a gradient than a binary construct. In addition to the SP and adolescents experiencing housing distress, other contemporary vulnerable groups of youth include pregnant adolescents (Ray & Roloff, 1994); delinquent and homeless youth (Forst, 1994); young women living in shelters (McGee, Morgan, McNamee & Bartek, 1995)

Sebastian's (1992) work on the causes and dimensions of vulnerability is useful in examining vulnerability and the SP. Sebastian cites socioeconomic and age-related factors as contributory to vulnerability and characterizes the consequences of these two attributes in the following way:

> Members of vulnerable groups often lack the knowledge of resources that would help them be more effective health care participants. They may not be effective self-advocates either because they lack political skills or because others hold stereotyped perceptions of them. (p. 368)

In reviewing discussions of vulnerability with the SP in mind, some relevant points arise. The SP is vulnerable on several dimensions. Building on the work of Sebastian (1992) Rose and Killen (1983), and Labonte (1993), the vulnerability of this group is characterized primarily by their relatively young age, the nature of the transition period in which they are developmentally located, and the low paying/ low status employment they secure. Of these factors, transitions as a contributing factor to vulnerability is the least obvious yet most directly associated with nursing. This is briefly discussed below.

Transitions

The concept of transitions has been identified as a central concept to the discipline of Nursing (Meleis, 1991; Schumacher & Meleis, 1994). Chick and Meleis (1986) identify four types of transition in their concept analysis of transition. These four types include developmental, situational, health-illness and organizational transitions. Adolescents as individuals and as a group experience a developmental transition by virtue of this period's normal developmental tasks that culminate in the transition into early adulthood. This period of de-stabilization between the development of identity as a young adult and the relinquishment of childhood status is pivotal and dramatic. All aspects of an adolescent's life undergo flux: physiological aspect, cognitive aspect and psychosocial aspect. Since the health decisions and strategy selections of adolescents will have an impact on their immediate health and influence their future health status, attention to these formative skills and influencing dimensions is warranted. During periods of transition, "when stresses tend to be greatest" (Stewart, Reid & Mangham, 1997, p. 22) resilience is a crucial factor. Resilience, taken as the ability to "balance stress and the ability to cope" (Stewart, Reid & Mangham, 1997, p. 22) may contribute to the ability to create successful, problem solving strategies, including strategies to cope with health conditions.

Accessing health services

Accessing health services and resources in JNP is central to the primary research question for this study. Access to health services has been identified as a determinant of health in its own right (Mustard & Frank, 1991) as an ethical issue (Aroskar, 1993; Daniels, 1982, 1985), as an area for nursing political action (Stevens, 1992), and as a pawn in current fiscally mediated health care reforms in the US and Canada (Addy, 1996; Birch & Abelson, 1993).

Bonuck and Arno (1993) provide two useful perspectives on the discussion of access to health care. First, these authors call for access to health care to be understood as "a multidimenisonal issue" (p. 213). Secondly, they differentiate between the Health Belief Model and the Health Behavior model, the two theoretical frameworks which they believe have commanded the debate on the topic. Bonuck and Arno characterize each of these models in the following way: "The Health Belief model places great emphasis on personal characteristics and subjective phenomena affecting health care behavior. The other, the Health Behavior Model...focuses on barriers to health care[1] posed by economic and sociostructural factors" (p. 213). Both of these models have important contributions to the study of the SP's accessing health care services and resources. Each model, along with other perspectives on help-seeking behavior, is briefly summarized below. The discussion on help-seeking behavior begins this section.

Cockerham (1986) explored the way in which "health seeking behavior for medical care relates to the wider range of behaviors in which people attempt to obtain services generally" (p. 83) and emphasized that "individual perception is the key variable in assessing modes of coping with problems of health and illness" (p. 110). As previously noted, many of these discussions are predicated on the medical/illness model, but this narrow focus does not discount their usefulness in the current context.

Other models developed to study help-seeking behavior include Aday and Anderson's (1975) Health Behavior Model. One of the five major elements of this model is "characteristics of the group at risk" (Aday & Andersen, 1975, p. 7). Cockerham (1986) depicts this element of the larger model as consisting of

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[1] These authors use a narrow construct of health care in their discussion. In the present study, a broader approach to health services and resources is considered.

> predisposing, enabling and need components which describe a person's decision to use health services. The predisposing component consists of sociodemographic variables and attitudes and beliefs about health care. The enabling component refers to factors such as family income, health insurance coverage, availability of services and access to a regular source of care. The predisposing and enabling components establish the conditions within which a person is or is not likely to seek health services when stimulated by need (health status, disability or diagnosis). (p. 103)

Aday and Andersen (1975) expound on the discussion of characteristics of populations at risk in the following manner

> Implicit in the access concept is the fact that certain categories of people have more or less "access" to medical care than others. The characteristics, which are biological or social "givens", such as one's age, sex or race (that appear as predisposing variables) or some of the community characteristics (urban-rural) in the enabling component, serve to define these groups. The more manipulable beliefs and enabling variables, such as income or health insurance coverage, are characteristics which health

> policy seeks to change, in order to affect these groups' access to care. The more manipulable components [are called] "mutable" variables the less manipulable "immutable". (p. 9)

Rosenstock's Health Belief Model (HBM), is an attempt to model factors that influence the mechanisms employed by healthy persons to avoid illness. This model also demonstrates the value of an individual person's perceptions about matter of health, illness and accessing medical care: "the individual's subjective assessment of the health situation becomes the critical variable in the utilization of health services" (Cockerham, 1986, p. 105).

Other contributions from the help-seeking discourse are Mechanic's (1968) ten determinants influencing a person's likelihood to seek medical care, which Mechanic called "factors affecting the response to illness" (p. 130); Suchman's (1965) stages of illness experience; and Calnan's (1983a, 1983b) work on managing minor disorders and social networks as influential in help seeking.

Although no literature regarding the SP and access to health services was found, other literature about low income populations and barriers that compromise access to health services is plentiful (Berne, Dato, Mason, & Rafferty, 1990; Himmelstein & Woodhandler, 1995; Johnson, Primas & Coe, 1995;, Stevens & Hall, 1992; Stewart, 1990; Thomas, 1994; Vagero, 1995). The role of financial status as a barrier to adolescents accessing health services has been addressed also (Lee & Grubs, 1995; Rew, 1995; Capan, Beard, & Mashburn, 1993).

For the present study, exploration of the SP members' perceptions of personal health issues and access to health services and relevant resources within their social context is vital. These individual and environmental dimensions contribute to compound this population's vulnerability which is characterized primarily by their relatively young age, the nature of the transition period in which they are developmentally located, and the low paying/low status employment they secure.

In the following chapter dimensional analysis, the methodology used to guide the current analysis, is discussed. Additionally, background information on grounded theory, from whence dimensional analysis evolved, is presented. Procedures employed in sample selection, recruitment, and data generation are also described.

3. Methodology

The Purpose and Overview

The purpose of this study was to understand perceptions of the SP about their personal health issues and access to health services and related resources. No studies regarding the Shadow Population were identified. Since little information was available on the study's population, a qualitative study using grounded theory methods of data analysis was planned (Field & Morse, 1985; Munhall, 1989). Grounded theory was selected as the guiding analytic framework because this strategy allows for the generation of theory that is directly tied to or grounded in the data collected by the researcher. Among the analytic strategies for deriving a grounded theory, dimensional analysis was chosen. To date, a limited amount of literature on dimensional analysis is available (Kools, McCarthy, Durham and Robrecht, 1996; Robrecht, 1995; Schatzman, 1986). It is appropriate to provide a background sketch of the evolution of different approaches to grounded theory methodologies culminating in a depiction of dimensional analysis.

The empirical[1] tenets of symbolic interactionism and its predecessor, pragmatism, are reflected in grounded theory (Corbin & Strauss, 1990) along with the systematic rigor of constant comparison reminiscent of quantitative methods such as factor analysis (Stern, Allen, & Moxley, 1982). This amalgamation of methodological frameworks reflects the synthesis of approaches to inquiry held by Glaser and Strauss as they began their collaborative work. The contributions from pragmatism, especially theory of action, and symbolic interactionism schools of thought are vital to the development of grounded theory and dimensional analysis. The evolution of thought leading to the distillation of these methodologies is presented for context.

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[1] empirical refers to "knowledge founded on experience, observation, facts, sensation, practice, concrete situations and real events" (Angeles, 1981, p. 74).

The irony of the current debate on the erosion of grounded theory lies in the respective positions held by Glaser and Strauss in light of the scholarly traditions in which they studied: Strauss, from the inductive Chicago school moving toward more structured, formalized manipulation of data during what is classically called grounded theory analysis; Glaser, from Columbia's deductive enclave, cautioning analysts to look at and nurture emergent concepts from data while avoiding excessive manipulation of the data.

Melia (1996) echoes Glaser's (1992) use of the term "full conceptual description" (p. 370) to describe the evolved approach to grounded theory that Strauss (Corbin & Strauss, 1990) have developed. This is in direct contradiction to Glaser's (1978) declaration that the focus of grounded theory is "conceptual specification...not full conceptual definition" (p. 64). Twelve years before the Straussian approach to grounded theory was presented, Glaser (1978) cautioned researchers on the dangers of overworking concepts under analysis:

> Data determined distinctions prevent the fracturing of a concept into too many dimensions or developing too many properties of it. The

> over elaboration of a concept becomes quite easy when using received distinctions with logical elaboration. That style of analysis inhibits, by burying in its excess, the true use and relevance of earned distinctions that have derived their meaning *only* from the data and then from their grounded, systematic connection with other discovered categories. Pairing down this excess from received distinctions, and using only those earned helps achieve the goal for theory of parsimony of concepts, while at the same time richly densifying concepts". (p. 64)

The depiction of the erosion of grounded theory approaches into Glaserian and Straussian camps (Stern, 1994, Wilson & Hutchinson, 1996) has heightened attention in this discussion. The debate has entered a new level with metatheoretical underpinnings (ontology and epistemology) of grounded theory entering the discussion in qualitative research literature (Annells, 1996; Melia, 1996; Quint Benoliel, 1996).

The commentaries on grounded theory eroding into two distinct methodological approaches have increased since the 1992 publication of Glaser's criticism of Strauss and Corbin's (1990) work which explicates in detail a framework to guide researchers in the conduct of grounded theory research. Glaser claimed that Strauss and Corbin's approach to grounded theory differed from the intent of the analytic process described by Glaser and Strauss in their 1967 work. Glaser (1992) contends that the Corbin and Strauss approach to grounded theory is more aligned with conceptual description than conceptual specification as Glaser described in 1978.

In the Tradition of Chicago's Action Scheme: Dimensional Analysis

Dimensional analysis is an approach for the analysis of qualitative data devised by Dr. Leonard Schatzman, currently Professor Emeritus at the University of California at San Francisco. Schatzman attended the University of Chicago for his doctoral studies in Sociology. During this time, Strauss acted as Schatzman's mentor. Previously, Schatzman's academic discipline had been history (personal communication, L. Robrecht, April 30, 1997). Later, Schatzman spent many years as a colleague of Glaser and Strauss at the University of California, San Francisco (UCSF) and co-wrote Field Research: Strategies for a Natural Sociology with Strauss in 1973. Schatzman identifies three circumstances that prompted him to develop dimensional analysis as an analytic strategy for handling qualitative data. In short, these circumstances were: a) the desire to develop an analytic strategy for qualitative data, b) inspiration from the development of grounded theory methodology, and c) experience from working with students learning about and conducting qualitative research.

Schatzman wished to identify or create an analytic strategy that was closely tied "with the analysis integral to interpretation itself" (Schatzman, 1991, p. 304). He characterizes this intent in a reflexive question that he developed to facilitate focusing by researchers using dimensional analysis. This question is "What all' is going on here?" (Schatzman, 1991, p. 310).

A second goal was to develop a grounded theory that both "provided a model with or from which to think and work: to follow, to critique, to draw from" (Schatzman, 1991, p. 304), and a platform on which to further discussions on method with his mentor, Strauss.

Two activities related to Schatzman's academic responsibilities motivated the final circumstance. These activities were reflection on insights gleaned from extensive experience in teaching field research methods courses and advising graduate students. Many of these students were using grounded theory as a methodology in their work (Schatzman, 1991).

Dimensional Analysis (DA) is clearly related to action theory and the Straussian approach to grounded theory in structure, yet it also demonstrates Glaserian characteristics in its avoidance of over manipulation of data in generating mid-range level theories in a grounded manner. Schatzman (1991) emphasized that DA is an attempt to focus on the structure of data analysis rather than on the process of the analysis. He provides insight into the origin of the structure (also called matrix) used to guide the natural analysis that he proposes occurs in the utilization of dimensional analysis. Of note is the fact that the DA matrix that guides the natural analysis is the same framework that Corbin and Strauss describe in axial coding (1990a). Historically, Schatzman reports interactions with UCSF students studying methodology with Strauss in the 1970s, who were struggling with the concept-in-formation of axial coding. Schatzman describes the terms dimension, property, context, condition, and consequence that were central to the confusion reported by students. In his analysis of the situation, Schatzman concluded that at that formative time, these terms were not clearly defined and consequently not used in a consistent way. For Schatzman, the salient feature emerging from the inconsistent use of the terms was the role of perspective:

> In formulating an answer [to students], I observed that what appeared as inconsistent was not a property of Strauss' reasoning, but rather a property of his use of perspectives on the data. By strategically subjecting particular codes to different perspectives, he was altering their meaning, necessitating their being located variously in an underlying matrix of the terms in question. Thus, for example, depending upon perspective, the code 'risk' otherwise simply one dimension or condition for action, or consequence of action or as 'risk/ing' can be rendered as action or process or as perspective.... It was then that I began to think of the matrix as providing a structure of terms that totally frame and give direction or methodological perspective to analysis, particularly in the context of explanation. (p. 308)

Explanation, Analysis, Discovery and Pragmatism

Schatzman's (1991) goal of explanation is reminiscent of Glaser's (1978) call for specification of the concept rather than definition. Schatzman describes the use of explanation and the role of DA's analytic matrix in the following way:

> An explanation, after all, tells a story about the relations among things or people or events. To tell a complex story, one must designate objects

> and events, state or imply some of their dimensions and properties--that is their attributes--provide some context for these, indicate a condition or two for what ever action or interaction is selected to be central to the story, and point to, or imply, one or more consequences. To do this , one needs at least one perspective to select items for the story, create their relative salience, and sequence them. Thus from perspective, in context, under conditions, specified actions, with consequences, frame the story in terms of an explanatory logic embedded in the ...[DA] matrix". (p. 308)

This sentiment reflects a pragmatic approach as paraphrased by Marks (1992): "Pragmatism is particularistic and contextual; it locates action, thought, and meaning within specific situations.... At the same time it acknowledges the relevance of different situations, providing some openness and variation in meaning" (p. 165).

Dimensional Analysis and the Shadow Population Study

Kools et al. (1996) state that "Dimensional analysis is an alternate method of generating grounded theory conceived for the purpose of improving the articulation and communication of the discovery process in qualitative research" (p. 314). Dimensional Analysis was selected as an analytic strategy for the present study for two reasons. First, DA fit the criteria of a qualitative approach that fostered grounded theory generation. Secondly, it is a pragmatically inspired strategy that allowed the capturing and analyzing of the situation (context) in which the SP made decisions regarding accessing health services in Jasper. DA, with its ontological antecedents of symbolic interactionism and pragmatism which emphasizes the context within which an action is situated as determinants to particular outcomes, (Strauss & Corbin, 1994), was well suited to the SP study.

Robrecht (1995) noted that "the aim of dimensional analysis is to discover the meanings of those interactions as they create the observed situation rather than the discovery of basic social processes" (p. 173). Logistical constraints associated with a population as difficult to access and recruit as the SP undermined thoughts of generating a theory to underpin a process. A concern about the ability to conduct more than one interview with any SP respondent was identified early in the study. This influenced the decision to use the DA approach, with its emphasis on a context--action--consequence structure, as an analytic guide.

General Design for Data Generation

The design for data collection in the SP study included a pilot focus group of SP respondents, two subsequent focus groups of SP respondents, a series of individual follow-up interviews with SP respondents, and a series of individual interviews with NSP respondents. The pilot focus group was held at the Banff Springs Hotel, 2 weeks prior to the onset of research activities in Jasper. All other focus groups and individual interviews were held in Jasper.

Focus groups were held with the SP respondents only, not with the NSP respondents. This design was deliberate. The focus of this study was the SP on whom no formal scholarly work has been done. Therefore the design was biased to maximize data generation from SP respondents. The SP-generated data was primary. Data collection from the NSP respondents was intended to provide data triangulation (Janesick, 1994) and to expand the analysis.

The data produced during the conduct of the focus groups served as abroad and diverse base (Asbury, 1995; Carey, 1994) for early data collection and analysis. The characteristic richness of data derived from focus groups is due to the multiple number of discrete responses from respondents and the group process that fosters emergent categories of discussion. This group process frequently allowed the SP participants to cue each other as fellow insiders and to expand on topics in a manner that a person outside of their group could not.

All focus groups and individual interviews were tape recorded after the nature of the study was explained, questions answered, and informed consents had been signed by the respondents. All tapes except the pilot focus group tape were professionally transcribed. Due to time constraints, the pilot focus group was transcribed in the field to allow for shaping of questions in subsequent focus groups.

The Pilot Focus Group

A pilot focus group was conducted to gain experience with the method and feedback on the initial guiding questions. The pilot focus group was comprised two female and one male respondents ranging in age from 19 to 23 years. At the time of the pilot focus group, all were working in Banff for the first season. Three primary benefits for the SP study were gained from the pilot focus group. Firstly, the shaping of questions for subsequent focus groups and individual interviews was facilitated. For example, wording in the original set of questions with accompanying 8 1/2 by 11 inch cards identifying determinants of health were changed. The term psychoneuroimmunology, originally used to satirize the obtuse nature of some formal medical terminology. This term was deleted and replaced by the phrase "having lots of stress can weaken your immune system". Secondly, the solutions used to resolve recruitment challenges with the pilot group provided valuable insight into recruiting strategies for SP respondents in the remainder of the study. The necessity for flexibility and spontaneity on the part of the researcher was underscored during pilot group recruitment. In spite of careful planning and pre-arranged logistics for meeting with respondents, the no show rate for the pilot was 100%. A new group of respondents was spontaneously recruited and the group conducted. Thirdly, logistical details were mastered, such as required length of time to cover all questions, the impracticality of flash cards to which pilot members were asked to respond, and familiarity with recording equipment for ease in manipulation and efficacy in taping.

Sample Selection

The anticipated difficulty in engaging and recruiting SP respondents was later confirmed by three factors around recruitment for focus groups. In retrospect, all three of these circumstances were initially encountered in the pilot focus group and reactive strategies were devised extemporaneously to accommodate the dilemmas. The three factors included difficulty in securing a commitment of off-work hours or free time by SP members for initial interviews or focus groups, a high failure to show for appointment rate on the part of the SP for focus groups, and clear statements by focus group members that they did not want to devote more free time to participate in follow-up interviews.

As in many aspects of the SP study, this difficult to access and engage nature precipitated a continuous creation of alternate strategies for recruitment. The closely related processes of SP respondent recruiting and sampling were two of the areas requiring creative problem solving in the field.

Inclusion and Exclusion Criteria.

Consistent with qualitative methodologies, the design of the study included purposive sampling, a non-probabilistic, non-representative sampling procedure in which criteria for inclusion in a study are based on a common standard or characteristic (Palys, 1992) The following inclusion and exclusion criteria were used to identify the purposive sample for either the focus group discussion or individual interviews: 18 years of age or older, understood and fluently spoke English resident of Jasper for 12 or fewer contiguous months, employed for the summer season in any full or part time service positions that support the tourism industry in Jasper, and could be a returning SP member from a previous season. Attempts will be made to recruit some SP members from the Jasper Park Lodge (JPL) staff. Permanent (more than 24 contiguous months) residents of Jasper who have been employed in seasonal positions were excluded.

Theoretical sampling was also employed. Theoretical sampling, employed commonly in grounded theory methodology, is defined by Glaser and Strauss (1967) as: "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyzes his data and decides what data to collect next and where to find them in order to develop his theory as it emerges" (p. 45). This more refined sampling procedure refers to the case where SP members are further selected on the basis of their ability to provide information on a given topic identified from preliminary data analyses.

The purposive sampling criteria identified by the inclusion and exclusion criteria were used in recruiting SP members for the pilot focus group held in Banff and the two focus groups held in Jasper. Individual interviews with SP members occurred after the focus groups had been held and the transcript of these focus group interviews were analyzed and coded. In recruiting members for the individual interviews, the purposive sampling criteria were assumed as baseline and additional criteria satisfying theoretical sampling were created. It was hoped that recruiting respondents who met both these sampling criteria would fill in gaps in data that were identified in early analysis of focus group interviews.

For example, two target subgroups among SP members that were recruited as a result of early theoretical sampling frameworks were SP members engaged in a romantic personal relationship and SP members who were employed in Jasper townsite rather than at JPL. Preliminary analysis (content analysis, category generation and review of sample characteristics for refinement of theoretical sampling framework) indicated that there was a gap in the information from SP members who were in a steady relationship. It was hoped that a picture of the effect upon SP respondents' health by their informal social support and social networks could be explored. In the second case, these early analyses indicated that the phenomena of living and being employed at JPL was a case unto itself and deserved its own study. In reality, the criteria created for theoretical sampling proved difficult to actualize. The overwhelming influence of the SP's difficult-to-engage nature prevailed. Snowball sampling, another non-probabilistic sampling method frequently used with difficult-to-access groups due to social or other barriers, proved successful.

Subsequently, the round of individual interviews was guided less by theoretical sampling and more by snowball sampling. The criteria for inclusion in these individual interviews became a SP member who met the study criteria and who agreed to and kept an appointment for a 1 hour interview. Further, most of the SP members who kept appointments for individual interviews were referred by a local key informant, such as the manager of Cavel Court or other person such as another researcher.

During recruitment of SP respondents for individual interviews, differentiation between this group and original focus group members emerged. This realization was an early indication that the SP was a non-homogenous group. The difference seemed based on age and to some extent attitude as demonstrated, by their selection of strategies to address health conditions. Because the focus group members were, on average younger and more spontaneous that the individual interview respondents, they were called the Adolescent Shadow Population or ASP. Once the significance of this differentiation was made it was continued throughout the analysis. This difference, of minor note during recruitment assumed more profound interest as analysis intensified, is discussed further in Chapters 4 and 5. The more general term SP is used to refer to both subgroups until the detailed discussion of this distinction in Chapter 4.

A second group of respondents was interviewed in this study. This second group are called the Non-Shadow Population (NSP). The sampling criteria for the NSP respondents included over 18 years of age, understood and spoke fluent English, employed or self-employed in a position of responsibility for the health and well being of the SP and/or the town of Jasper e.g. member of Jasper National Parks Administrative Staff, Jasper School Board Member, health or social service provider). A SP employer could be included. The NSP were permanent residents of Jasper townsite who had direct or indirect responsibility for the health and well-being of the SP and/or the town of Jasper. These NSP Jasper community members included health care and social service providers, a Jasper Improvement District (ID) member (the ID in Jasper is analogous to a town council), an RCMP officer, and a Canadian Parks Service employee with administrative responsibilities for the town site. At least one member of the Parks Service was included because currently, Parks Canada retains responsibility for municipal governance of Jasper and administration of the larger Jasper National Park. NSP respondents were recruited for their enriching intersectoral contributions to emerging understanding of the SP in the context of Jasper.

Recruitment of the SP: Two Phases

Recruitment strategies had two phases. These phases included a preliminary foundation building phase and an active recruitment phase. These phases were overlapping rather than occurring in sequence due to concerns about the effort/time required in recruiting the SP as indicated by difficulties encountered in the pilot study.

The foundation phase. The foundation phase focused primarily on public relations within the small town of Jasper. The official Parks Canada contact person for this study requested the completion of several activities prior to the onset of active SP recruitment: a letter of notification and offer to make a presentation to both Jasper's Chamber of Commerce and Westview Regional Health Authority; an article on the SP study as one of several community-based research projects conducted in Jasper in the summer of 1995 to be published in the local newspaper, The Jasper Booster; and personal contact with a few employers of the SP. The activities associated with letters and the newspaper article were completed prior to the first focus group.

Active recruitment phase. The preliminary strategy used to recruit any SP members in the active phase was both unsuccessful and, it was later learned, a source of amusement to many SP members. This unsuccessful strategy was based on the distribution of recruiting flyers including a response telephone number. It was believed that potential respondents would call the phone number provided and arrange to meet the researcher for a focus group or an individual interview.

These flyers were distributed personally to every hotel restaurant, sports shop, bicycle shop, bulletin board, and other visible location for information in Jasper. The business locations to which the flyers were delivered were obtained from the Jasper Telephone Directory. The flyers were clear, succinct and included removable tabs on which the study phone number was printed. The flyers described the study and asked SP members to phone the researcher. An answering machine was hooked up to the local number provided on the flyer. Not one phone call was received on this dedicated answering machine.

The aspect of this strategy that became a source of amusement for many SP members was learned in the second focus group. The flyer strategy centered on telephone access. Deposits for personal telephones in Jasper are very high and subsequently, the majority of SP members do not have them. The high telephone deposit is a reflection of past indiscretions by the SP, seasonal, or other transient residents in Jasper. In the past, some members of the above-named groups have left Jasper without paying telephone bills. These bills were, on occasion, quite sizable. Public telephone access is available but not always convenient. It is believed that this barrier to convenient and private telephone access contributed to the failure of the flyer recruitment strategy.

The focus on recruitment then shifted to areas of concentration of SP members' accommodation and the employment of a community key informant or gatekeeper to facilitate recruitment. The manager of Cavel Court, living accommodation complex located on the edge of Jasper where a large number of SP members reside, proved invaluable in this role. As a person trusted by the residents of Cavel Court, the manager's introduction to potential respondents was key in successful recruitment for the study. In this case, the role of key respondent/gatekeeper was one of allowing access to the population rather than restricting access.

The manager became aware of and involved in recruitment for the SP study during the distribution of the above-mentioned flyers. His offer to facilitate meetings with SP members was welcomed and became a crucial turning point in the conduct of the study.

Organizing SP focus groups. Initial attempts to schedule a focus group with Jasper SP members were not successful. In spite of introductions by the manager, the first scheduled focus group did not occur because the respondents did not show up. Upon follow up in person and by note, these potential respondents indicated that they were unable to/uninterested in rescheduling another group. Although disappointing, previous experience with the pilot study foretold this occurrence.

In the pilot focus group, held in July 1995 at the Banff Springs Hotel (BSH), none of the original pilot group members kept the appointment at the slated time and place. This occurred in spite of careful planning in cooperation with the BSH Human Resources Office. The pattern that was successful for the recruitment of the pilot focus group members presaged the approach that later proved successful in Jasper. This approach is detailed below.

After the original pilot group members did not show up for the pilot group, the BSH Human Resource Office located a summer worker who was able to spend 2 hours with this researcher, to answer the prepared questions. Although it was anticipated that the questions would take approximately an hour to complete, a generous amount of time was added for critical feedback from the pilot group members on the substantive content and process of the focus group. One available and willing SP member from BSH was located by the Human Resource Office. This researcher then requested that the SP volunteer recruit three or four friends who were not working at that time. Three friends responded, consented, and spontaneously formed a group.

In the organizing of both focus groups in Jasper, similar difficulties in scheduling arose. The strategy that was ultimately successful in recruiting members for the focus groups was a combination of snowball sampling as used in Banff, spontaneous group formation, and cooperation of a key informant. With the manager's assistance, SP members who had come to work in Jasper and live in Cavell Court in the summer of 1995 were identified. The manager approached these persons and determined interest in participating in the study and willingness to have their names shared with the researcher. He then made a short list of these potential respondents and gave the list to the researcher.

The researcher then approached individuals or sets of roommates on the list and further explored interest in participating in the study. The actual approaching of potential respondents was scheduled in cooperation with the Cavel Court management, since their security measures precluded general access to the residents' accommodations. The potential respondents were approached in the late afternoon. This time was chosen because many SP members who work day shift return to Cavel Court between 15:30 and 16:00.

Less than one quarter of the individuals on the manager's list of prescreened potential respondents were interested in further involvement in the study. Many of these persons stated that they were tired after working that day, had plans to meet friends after work or, after some thought about the study, were not interested. When one of the individuals on the prescreened list demonstrated interest in the study, the researcher requested that this individual recruit a few friends who were available at that time (immediately) to form a group. The first individual who had stated interest in further involvement in the study did not want to involve others. This person was scheduled for a later individual interview and thanked. (The subsequent interview did not occur. This individual was not able to/uninterested in rescheduling an appointment.) The next person on the dwindling list of potential respondents was interested in contacting friends to spontaneously form a focus group. The respondent criteria was reviewed with this crucial respondent to guide the selection of friends as potential focus group members. The focus group, in this way, took on a congenial and light atmosphere that would facilitate the group's dynamics. The purpose and nature of the study was explained to the potential group members and the study criteria were explained. After respondents' questions were answered, consent forms were completed by the respondents.

The second focus group formed spontaneously at Cavel Court when one SP member saw a study flyer that had been posted less than an hour earlier in the Cavel Court lobby. This SP member contacted the manager and relayed his interest. Within minutes, the researcher returned to the lobby from follow-up checks on potential respondents on other floors in Cavel Court. The interested SP member was contacted, friends recruited, and a spontaneous focus group occurred.

Glitches and successes with focus groups. In spite of the two reviews of study criteria, some of the SP friends recruited by the crucial respondent did not match the inclusion criteria. This occurred in the formation of both Jasper focus groups. The unmet criteria were either language or length of residence issues. In one case, a group member's first language was French, not English. His receptive and expressive communication skills in English were functional, but not fluent. In a few other instances, the individuals had lived in Jasper for more than 12 consecutive months.

These persons were not excluded from the group because it was felt that the dynamics of the focus group might suffer if some recruited friends were excluded. This decision proved beneficial. Inclusion of these persons provided contrasting experiences, added rich context and detail to the discussions, and facilitated group dynamics.

In summary, in spite of many challenges, some elements of the recruitment process provided marked contribution to its success. Experiencing both the challenges and the successful elements was, in retrospect, natural in the conduct of research in such uncharted waters. Several elements contributed to the successful recruitment of SP respondents. These elements which may be useful for recruitment of other hard-to -reach youth and young adults, include: cooperative working relationship with a gatekeeper or valued member of the population to be studied; acknowledging the value of the potential respondent's time both leisure time and constraints of work schedules; readiness and ability of researchers to spontaneously shape plans for interviews/focus groups in response to respondent requests i. e. timing, place of meeting, and to some extent, group participants; need for persistence and patience on the part of researchers in recruitment attempts; and of great importance, respectful consideration of the respondents, their opinions and suggestions.

Other Good Intentions and Best Efforts in Focus Group Recruiting. Attempts were made to hold a focus group with persons whose common characteristic was not living accommodation, i. e. residing in Cavel Court. These attempts were unsuccessful. The subgroup targeted for this unsuccessful focus group were avid mountain bicyclists/outdoor activity enthusiasts. This group was sought because, as later explained, SP respondents identified the SP as characterized by party seekers and outdoor enthusiasts. In half a dozen instances, the researcher spent periods of time in a popular mountain bicycle sales and rental shop, attempting to schedule or form a spontaneous focus group. Managers of the shop were very cooperative and even tried to facilitate introductions with known patrons, similar to the role the manager had played at Cavel Court.

The Health Unit in Jasper graciously offered space for the group if it were to materialize. There was no interest or cooperation from SP members approached in the bicycle shop. During this time, attempts to recruit SP members employed in river rafting operations were also attempted, but proved unsuccessful.

Two different reasons for the lack of success in recruiting from these 2 subgroups are speculated. Among the bicycle riders, it is surmised that recruitment proved unsuccessful because outreach for the project was made while the members were preparing to embark on a cherished avocation during time off from work. It is less clear why recruitment attempts were not successful among river rafting personnel. Possibly the lack of any face to face contact with these SP members was a salient factor. The power of personal; communication in this activity cannot be underestimated.

Recruiting Respondents for Individual Interviews. Individual interviews were scheduled with SP respondents. Having learned the value of a key informant to access and recruit SP members, this strategy was again used for individual SP interviews. Working with the Cavel Court manager, an attempt was made to recruit individual SP respondents who would be able to fill in gaps in information as well as to respond to the concepts forming in early analysis. For example, attempts were made to recruit a SP respondent who was in a steady personal relationship an employee of JPL for an individual interview. Two potential respondents in this category identified by the manager, including one respondent who also had a young child, were approached. Neither of these individuals were interested. With persistence in this strategy, five SP respondents were recruited for individual interviews and, capriciously, three of these respondents were in steady personal relationships and one respondent was employed at JPL.

Recruiting NSP respondents was easy in comparison to the SP recruitment. Most NSP members could be reached at a professional office or at home. Interest in the study was high and scheduling appointments was straightforward. Eight NSP respondents were interviewed.

In February 1997, a series of validation interviews were conducted with SP members. The purpose of the validation interviews was to bring the salient features of this study's analysis back to members. The goal of the validation groups was to ascertain if the findings as summarized and presented to SP members, held a ring of truth to their experience. In order to accomplish this, the findings were presented by the researcher in an informal verbal presentation rather than through specially crafted questions. Validation group members were asked then to respond to the content of the presentation for congruence with their experience and perceptions on the topics presented.

Initially, similar difficulties in reaching potential respondents were experienced. The manager at Cavel Court (not the same person as the summer of 1995) proved helpful again. Four of the five validation interviews were held with Cavel Court residents. The fifth interview was at the Whistler's Youth Hostel. A more informal and spontaneous manner and collaboration with a key informant who was trusted by SP members, again proved to be components of a successful strategy. These successful approaches and not unlike elements used in participant observation and ethnographic filed research (Atkinson & Hammersley, 1994; Spradley, 1979).

Data Collection and Analysis Overview

As articulated previously, the majority of challenges in the data collection process were associated with recruitment. Group participation in pilot and other focus groups occurred freely and spontaneously with 2 exceptions. These exceptions involved an episode in focus group two related to determinants of heath questions and a general uneasiness at attempting to respond to questions linking environmental health with human health on either a personal and community scale. Both these situations are discussed below.

During the second focus group, in the section in which SP members were asked to provide their perceptions of the meaning of a series of discrete determinants of health (e. g. socioeconomic status, social support, access to health, education, psychoneuroimmunology, etc.) in their lives one group member became upset and left the group for 5 to 8 minutes. The topic precipitating this reaction was education. Upon this member's return, she expressed dismay at the importance she perceived was placed on formal education and the lack of acknowledgment given to life experience such as she was experiencing in Jasper. She added that she had left university in her home in an eastern province the previous year and had come to work in Jasper.

The questions exploring the associations between environmental health and human health on a personal and/or community scale proved difficult for SP, Other and NSP respondents alike. There appeared to be understanding of the questions, but difficulty in articulating awareness of associations among the concepts. Several respondents remarked that they had never thought of the connections before. This area remains fertile for more study. The ultimate shift in focus of the study to topics related to the primary research question was due, in part, to the difficulties in addressing these two areas of inquiry.

Individual and group interviews provided different and complementary responses to the research questions. This complexity of responses is seen as a strength of the study. There are two apparent reasons for the divergence and complementarity of responses in group and individual interviews.

The first reason is based in the study design. Focus group questions were intended to identify the widest possible range of respondent replies. The intent in using this format was to strive for saturation in topics held to be salient to the population regarding the areas of inquiry. For this reason, the focus groups preceded the individual interviews. Individual interviews then provided a venue for in depth exploration of categories that emerged from focus groups.

The second cause for responses of differing nature rising in group and individual interviews is based in group dynamics as opposed to the dynamics of a dyad. The properties of group processes in the focus groups allowed for the emergence of wide range of topics as group members spontaneously responded to researcher's questions and group members responses alike. Since group members were acquainted with each other at the onset of the groups the dynamics of the group interviews were characterized both by rich momentum and conversational give-and-take, and relatively few barriers.

The questions used in both group and individual interviews were derived from the overarching research questions. Since the scale of the research questions were both highly abstract and were not well suited for general conversation, a series of more concrete questions for each of the overarching research questions were constructed (Appendices A and B). These questions were used in the pilot group, slightly modified and used for the subsequent focus groups.

Other data received from participants were captured from responses to biographical information forms. This primarily demographic information was sought to augment decisions directing theoretical sampling. While theoretical sampling is primarily concept driven, it was hoped that examination of emerging concepts in relation to information on gender, age, number of jobs held, etc. might provide information on potentially valuable trends or even negative cases to be explored.

Data analysis began immediately after the pilot focus group was held. The tapes of this group were transcribed by the researcher within a few days. The transcripts were then coded in order to explore the concepts revealed by the respondents. Guided by the responses from the pilot focus group, the focus group research questions were refined and clarified. The remaining interview tapes were transcribed professionally. Upon receipt, all transcripts were subjected to open coding and then a second round of coding that produced more abstract concepts. After all transcripts had been coded, a decision was made to employ computer software to manage the data and continue the analysis. This decision was made in part to facilitate management of the large amount of data, as the cut and paste phase of the analysis was to begin. The software chosen was Q. S. R. NUD*IST (Non numerical Unstructured Data Indexing Searching and Theory-building developed by Qualitative Solutions and Research Ltd.) or NUDIST. Other factors supporting the decision to use NUDIST software included the growing prominence of the use of this software in the qualitative research community. The opportunity to compare the coding outcomes between software mediated and manual approaches proved valuable. The coding process was augmented by the development of evolving figures and diagrams depicting the emerging picture. These diagrams of code categories were then extrapolated to categories in the DA analytic matrix.

These categories provide the differentiating labels for the context mediated dimensions that comprise the analysis. The categories, created to facilitate answering Schatzman's touchstone question guiding analysis "What all is going on here?" are attributes, context, conditions. Definitions of these categories appear below.

Attributes are expressed as a property and this property's dimension. Schatzman (1986) describes attributes in this way:

> With attributes--that is, with dimensions and properties, we go beyond denotation to description and to connotation: the language of values, uses, and the implications of things and events are brought into cognitive view. The shapes, sizes, costs, durability, visibility, etc., and their measures are involved in the use of these attributes. Indeed, any description or measure of something experienced is either dimension or property. The two attributes are necessarily and inevitably linked:

> dimension provides an abstract context or reference for property, and property provides for its dimensional referent a descriptor or measure. (p. 5)

Schatzman refers to the *context* component of the dimensional analysis matrix in this way:

> Context signals parameters or boundaries within which the inquiry will be confined, "telling" what sorts of considerations are permissible and which are not. It includes all the "givens" in the situation to be analyzed. But it is relatively static as it contains all the properties which gain admission to its confines. (p. 6)

Kools, a student of Schatzman, provides the following representation of *condition* in Kools et al. (1996):

> Conditions are the most salient of dimensions. Conditions, by nature of their relative importance to a given phenomenon, have an impact on actions and interactions. Conditions are dimensions of a phenomenon that facilitate, block or in some other way shape actions and/or interactions --the processes of a given phenomenon (p. 318).

Designation is the process in DA by which elements of the situation or phenomena in question are relegated into the dimensional categories of the analytic matrix. In this way, a vocabulary specific to (or grounded in) the analysis at hand is generated. Robrecht (1995) characterizes designation and then the effect of operationalizing the DA matrix in this way: "The act of designation moves a particular observation toward a more abstract representation of the event. The model provided by the explanatory matrix outlines the researcher's analytic process and represents the structure of the resulting explanation". (p. 173)

Guided by DA, findings are summarized in matrix form reflecting attributes, context, conditions, actions, and consequences characteristic of the identified perspective in relation to managing perceived social risks associated with personal health issues. Study findings are presented in the context of this framework in Chapter 4. Table 1 is a template of the dimensional analysis matrix framework used in the study.

Table 1

Dimensional Analysis Matrix

Perspective:

Attributes	Context	Condition	Action	Consequences

Rigor and Method

The present discussion focuses on some of the issues in achieving and protecting rigor in qualitative data collection and analysis and the specifics related to the SP study. Sandelowski (1986) discusses the crucial tasks of achieving and maintaining rigor in qualitative research. Building on the work of Guba and Lincoln (1981), she identifies a four factor framework to guide these two tasks. The four factors set out in that discussion are used to guide the present study: credibility, fittingness, auditability, and confirmability. These are directly analogous to Guba and Lincoln's series: "...truth value, ...applicability, ... consistency and ...neutrality" (Sandelowski, 1986, p. 29).

Central to the achievement and maintenance of rigor in this, as other qualitative studies, is fidelity to the reflective documents kept by the researcher. These documents which capture subjective and objective reflections of the research process are the field notes, journal, memos, and diagrams.

Credibility (internal validity/truth value) is maintained when there is confidence that the findings of a study are characteristic of the variables being studied and not of the investigative procedure itself (Sandelowski, 1986). In this study, credibility will have been achieved if the data generated from the focus groups and interviews reflect the attitudes, decisions and choices of the respondents regarding their thoughts on health and access to health services in Jasper.

Fittingness (external validity/applicability) reflecting the generalizability of the study findings is achieved when "the findings of the study, whether in the form of description explanation or theory, "fit" the data from which they are derived. The findings are well grounded in the life experiences studied and reflect their typical and atypical elements" (Sandelowski, 1986, p. 32).

Efforts to protect the rigor of this study included using the previously mentioned reflective documents (memos, notes) to monitor potential researcher biases. At the close of each group and individual interview, formal field notes were dictated into a tape recorder. Supplemental field notes or theoretical memos that emerged in the days between interviews were also dictated into a tape recorder. These notes and memos were transcribed professionally and subsequently entered into the NUDIST database for analysis in conjunction with the interview transcripts. The analyses of interviews, filed notes and preliminary theoretical memos gave rise to subsequent generations of theoretical memos, diagrams and figures.

In addition, regular contact and discussions with colleagues including committee members were employed to examine the structure and results from the pilot focus group, individual interviews with the SP and NSP respondents, and all stages of data analysis; triangulation of data collection; and individual interviews with respondents to clarify and validate categories.

Auditability (reliability) is achieved in a qualitative study when "another researcher can clearly follow the 'decision trail' used by the investigator in the study" and " another researcher could arrive at the same or comparable but not contradictory conclusions given the researcher's data, perspective and situation (Sandelowski, 1986, p. 33)". Documentation of the design, field notes, memos, and diagrams were maintained during the conduct of the study. These documents are prominent in protecting the study's auditability. In the present study, a remarkably robust and weighty (pound per pound) collection of documents, memos, figures, document drafts, etc. are available.

Confirmability is the final factor in Sandelowski's (1986) discussion of rigor in qualitative research. Confirmability is comparable to the concept of neutrality. Indication of attainment of confirmability is "when auditability, truth value (credibility) and applicability (fittingness) are achieved" (p. 33).

Ethics

Ethical standards according to the guidelines set by the University of Alberta and the Faculty of Nursing were upheld in the study. Confidentiality and anonymity were protected as much as possible in the pilot focus group in Banff and the two subsequent focus groups in Jasper. The nature of group participation denies absolute protection of either principle. Appropriate steps were taken to protect tangible research material such as consent forms, tapes, respondent biographic forms, etc. during the active interview phase. These materials are presently stored in a secure and appropriate manner.

Concluding Thoughts

As an overall approach to the present study, an inductive framework was shown to be appropriate. The elusive nature of the population and the restricted time within a summer season in which this group was available would have created difficulties in operationalizing a study design that included mailed questionnaires or phone surveys. It is believed that response rates would have been quite low with these designs.

As an analytic structure, Dimensional Analysis proved to be a useful approach in the present study. The flexible structure provided by the analytic matrix provided guidance for consistent analysis of the data while allowing fluidity in identifying and verifying the perspectives to guide the overall analysis. It does not seem that the data became overly manipulated or distorted by this analytic strategy.

4. Findings

The research question addressed in the current analysis was: How do members of the SP perceive their personal health issues and access to health services and related resources? In this chapter, I present a summary of the characteristics of the respondents who participated in the study and a discussion of the central perspective on personal health issues which emerged from the data analysis managing perceived social risk. Strategies employed to control perceived social risks, conditions which influence strategy selection, and the consequences associated with use of risk-managing strategies will be addressed.

Sample

Categories of Informants

Three original categories of informants appear in this study: Shadow Population (SP) members, Non Shadow Population (NSP) members, and Other informants. As analysis of the data progressed, more refined designations within the SP group became apparent. Shadow Population, refers to the informal name given by health and social service workers in Jasper to the young adults who come to Jasper National Park to work seasonally in service jobs that support the tourism and hospitality industry. This definition was created prior to the advent of the study. Non Shadow Population refers to informants who were permanent residents of Jasper and have responsibility for the health and well being of Jasper's temporary and permanent residents. Other designates two informants who did not fit easily into either the original SP or the NSP designation. These two informants were included in the study because their perspective as professionals who provide health and/or social services for the SP in Jasper was deemed valuable for the study, although they clearly did not meet the criteria of NSP. One of these informants worked seasonally and had responsibility for the health of SP members. The other had previously worked in a capacity that would have classified this informant as NSP.

NSP respondents were included in the study in order to provide a different and supplementary dimension for the analysis of the area of inquiry. Since this is the first known systemic inquiry involving the SP, the widest context possible was sought in which data collection and analysis would be performed. The number of NSP respondents was arrived at by a different approach than that of the SP respondents. The sectors in which the NSP respondents worked were identified as potentially health supporting for the temporary and permanent residents of Jasper. After identifying these eight sectors, the primary organizations in the sector were contacted and a request for an interview with a representative from each was made.

Two Study Segments

Sample selection was conducted for two main segments in the study: a data gathering segment and a validation segment. The data gathering segment included focus groups and individual interviews. The validation segment included individual interviews. Below is a description of these two segments.

Sample in the Data Gathering Segment

In the data gathering segment, a total of 28 informants were interviewed. In this set, 18 informants were SP members, 8 informants were NSP members, and 2 informants were categorized as Other. The sample size for the SP group was determined by saturation of the data. That is, the categories among SP responses began to repeat, demonstrating the "valu[e] of variation over quantity" (Morse, 1995, p. 147) of responses. All data gathering interactions with these informants were conducted during the summer and fall of 1995. (See Table 2).

Table 2

Distribution among three groups of informants in data gathering section

Informants	Focus Groups			Individual Interviews	Total
	Pilot	Focus Group 1	Focus Group 2		
SP	3	4	6	5	18 SPs
NSP	--	--	--	8	8 NSPs
Other	--	--	--	2	2 Others

The age of the SP respondents participating in focus groups and individual interviews is an important feature. Most of the focus group members were in their late teens or early twenties. One of the members of

Focus Group 2 was 24 years old. The respondents participating in individual interviews ranged in age from 21 to 26 years of age.

Sample in the Validation Segment

Five validation interviews were held in the winter of 1996 when most of the data analysis had been completed. The purpose of these interviews was to validate and refine the theoretical framework that emerged from the data analysis. Attempts were made to recruit late adolescents for the validation group; however, this plan was not viable. Reminiscent of earlier recruiting attempts, persons responding to requests for an appointment to interview them were older than other persons in their late teens who were also approached directly or through a local contact person.

In line with previous sampling and recruiting challenges, the cohort in the validation group was a poor match for the focus group members in the data gathering segment. While some discrete pieces of information from these interviews was useful, by their own admission members of the validation group were different.

> Josie: I think that the summer time is different here from the winter.... The summer people seem to be more frivolous... they're not as concerned because maybe they're going home or maybe it's not a long term thing. If they're looking at some kind of serious illness, I'm sure that they would wait.
>
> Jane: Those people are just seasonal. All they want to do is work, party and who cares...and they're leaving in the fall. That's everybody's plan for the summer.

Characteristics of the Shadow Population Respondents

SP Respondents in the Data Gathering Segment. The 18 SP in the focus groups and interviews in the Data Gathering segment included 15 from Jasper and 3 from the pilot focus group in Banff. Of these, seven were male respondents ranging in age from 18 to 26 years of age. Six of the seven males reported that this was their first season working in Jasper. The seventh respondent did not provide that information on the biographical data sheet filled out by all informants, nor in the group discussion. All the male SP respondents held at least one full-time job in the hospitality or tourism industry. One male SP respondent held an additional part-time job as a waiter.

There were 11 female SP respondents ranging from 19 to 30 years of age. Seven of the 11 females reported that this was their first season working in Jasper. Ten of the female SP respondents held at least one full-time job in the hotel or tourism industry and five of these women reported holding an additional part-time job. One female SP member reported a different employment pattern. This SP informant held a part time job in the tourism industry but her primary job was in a Jasper service industry catering to permanent residents, transient residents, and tourists.

In the Banff pilot focus group, two of the three pilot group respondents were female. The age range for this group was 19 to 23 years of age. All pilot group respondents were first time residents and workers in Banff. The range of their stay in Banff was 2 to 11 months. Two of these respondents were employed in the housekeeping department and one was an office clerk.

Characteristics of Validation Segment Respondents. The respondents in the Validation segment had the following characteristics. Four were female and one was male. The women ranged in age from 19 to 23 years of age. The male was 21 years old. All held full time jobs in the food service or ski industry. Four of the five stated that they were in (heterosexual) relationships with steady boyfriends or girlfriends. The first two respondents interviewed were in fact a couple. All respondents in the Validation group had been in Jasper for less than 12 months. Three of the five had been working at Jasper since the summer of 1996.

Characteristics of the Non Shadow Population respondents

Eight NSP informants were involved in the data gathering segment of the study exclusively. All eight NSP informants were permanent Jasper residents whose jobs placed them in positions of responsibility for the health and well-being of all residents of Jasper. These positions included direct patient care or coordination in health and social service agencies, municipal positions impacting on law enforcement, town management, and business regulation and promotion. Two of these NSP informants' positions were volunteer positions. The remaining six NSP informants were remunerated for their work.

Of the eight NSP informants, one was a male in his early 40s. The remaining seven NSP informants were women ranging in age from 29 to 50.

Seven of the eight NSP informants had held their jobs in Jasper for 4 to 14 years and five were previously SP members in Jasper and/or Banff. The remaining three NSP had no experience working as a SP member in any setting.

Characteristics of Other respondents

Other informants included two women who were in their early to mid-twenties. These informants worked in a professional capacity with the SP and other young adults in Jasper as health/social service professionals. One had prior experience as a SP member in Jasper.

Subgroups of the Shadow Population in Jasper

At the onset of this study, the SP were believed to be a homogenous group. SPs, seasonal workers, and transient workers were perceived as synonymous terms. As focus groups and individual interviews were held, a complex structure of Jasper's transient and seasonal workers emerged. Among transient workers, even the SP became recognized as a complex group with several subgroups. A clarification of the SP and Jasper's seasonal workers is provided to begin this discussion.

Identifying the boundary: The discovery of the Adolescent Shadow Population (ASP)

In this study, the age and related developmental stage of SP informants evolved as an important factor. Within the SP informants, two groups of respondents emerged: the younger, more spontaneous group and the slightly older, more established informants. The younger group, called Adolescent

Shadow Population members, primarily participated in focus groups. The other group, who were interviewed individually, are referred to as SP members.

Reviewing demographics of the sample indicates the differentiation in the two groups. In the data gathering section of the study, the mean age of all respondents originally categorized as SP members was 20.9 with a range of 18 to 26 years of age. (Members of the pilot focus group are not included here.) The mean age of focus group members was 21.5 years with a range of 18 to 24 years of age. This number is high because one of focus group members was 22 and one was 24 years of age. If the mean age of the focus group members is taken without the outlying age of 24 years, the average drops to 19.6 years of age.

The mean age of the SP members interviewed in individual interviews was 22.6 years of age. The range of individual SP interviewees was 20 to 26 years. In the validation section, the mean age for validation interviewees was 21 years. The age range was 19 to 23 years of age.

Among the SP, a division of younger, more transient workers and somewhat older workers who tended to remain in Jasper longer than one summer season was identified. This younger group of SP respondents, ASP members, primarily comprise the group of transient workers who come to Jasper for a summer season. Some of these ASP stay on in Jasper. This decision to remain longer than the summer season relegates an individual into the category of SP.

In the course of the present study, a rough continuum of transient and seasonal workers was devised. As stated, ASP members are seen as the youngest and most transient, coming to Jasper for a summer of work. Other persons, including some SP informants who contributed to individual interviews, came to Jasper in search of seasonal work with the intention of staying on past the summer season. For some of these individuals, this decision was predicated on a desire to take time off from college. For others, also arriving in the data gathering summer of 1995, economic hardship in home provinces (from Alberta to Newfoundland) led them to Jasper in search of employment. Occasionally young persons come to Jasper for seasonal work during the winter ski season, but this is a smaller number than the summer group by several thousand.

Other Shadowy Subgroups

Due to housing shortages in Jasper during the summer season, some SP members live in cars on the streets of Jasper or in one of the many JNP camp sites. Campsite dwellers abide by JNP regulations and regularly move their tents every 10-14 days. NSP respondents from the health and social service field expressed concern for these SP members regarding the challenges they face during episodes of illness. Maintenance of hygiene and adequate hydration pose a logistical difficulty when place of residence lacks self-contained sewage, running water, or heating facilities. While none of the campsite dwelling nor car-dwelling SP members were included in the present study, they were not intentionally excluded. Their existence became known to this researcher late in the Fall of 1995, after data collection with the study's SP groups had been completed. The unusual experience and particular health needs of these SP members is worthy of investigation.

Shoulder Season: From Shadow to Seasonal

Some summer SP members decide to stay on in Jasper for a season or two. This group makes an interesting transition from anonymous temporary worker outside the permanent Jasper community to a more integrated, recognizable member of the community. The time when this transition occurs is known to local residents as Shoulder Season. Shoulder Season, which is shrinking due to increased pressure to expand tourism opportunities, was traditionally the breather period for permanent residents from Labor Day to the beginning of ski season. During this time summer jobs evaporate and housing arrangements and employment opportunities for SP members deciding to stay on become scarce. This is a highly pressured and difficult time for this group of SP members.

Permanent residents of Jasper include a number of individuals, for the most part older than this study's sample, who have lived in Jasper for 10 years or more and work at seasonal jobs year round. These individuals shift the focus of their employment with the changing seasons and concomitant opportunities offered by a tourist town. This latter group, called "Peter Pans" by some local health and social service professionals, have become an integral part of the permanent Jasper community. Because of this group's age, relatively lengthy stay in and integration into the community of Jasper this group was not included in the present study.

Jasper Park Lodge: A world unto itself

Only one current Jasper Park Lodge (JPL) employee was included in the present study. This respondent was among the individual interview group of SP members. Another individual interview respondent had worked for JPL in the past, but at the time of her interview she was working in Jasper townsite. Her input on the contrasting experience of working and living on the JPL grounds as opposed to the Jasper townsite was fascinating and useful in identifying the JPL experience as deserving its own study. Early on, indications led to this exclusionary strategy. The geographic isolation and self-sufficiency (infrastructure and culture) of the JPL community is believed to shape the experience of JPL workers differently from workers who reside and work in the town site. Respondents who discussed JPL even mentioned tensions between JPL workers or "Lodgies" and "Townies" as town-based ASP/SP are called.

JPL employees have their own structure of summer and more long-term job holders. Of note with the summer employees is the incidence of hotel management students who work as a school placement at JPL. During this study, no information was gathered regarding long-term JPL employees, known as "Lifers" among the JPL community.

Temporal Influence on ASP

The time limited nature of many ASPs stay in Jasper adds to an element of surreality to the Jasper experience. Many ASP members come to Jasper knowing that their stay will be summer long. At the end of the summer, they will return to their normal life back at school or with their families. This artificial return to normalcy is a few months away. Many problems including management of personal health issues of potentially serious consequence can be forestalled for this period of time. Comments from validation interviews confirmed this assumption.

In this study, the potential effect of the ASP/SP's perception of the length of their stay in Jasper as an overall influence on their decision making and priority setting was explored. Those ASP members who see themselves as staying a short summer season seem less likely to become engaged in the Jasper community and less likely to demonstrate long-term planning strategies including strategies that have impact on their health. More focus seems to be placed on the present and enjoying the finite pleasures available while in Jasper for a summer. For those who plan to stay for more than one season, or those whose plans change to staying in Jasper more than one season, this approach to long-term planning changes. Decision making and priority setting patterns seem to differ in these two groups.

This brief holiday from routine patterns in the form of a summer working in Jasper creates a sharp differentiation for ASP/SP members between life in Jasper and life at home. One SP member commented on the surreal nature of living in Jasper. For this reason, this informant cautioned that maintaining contact with friends at home is an important tip for all SP members:

> Well it's like a different world in here. It's different and you start to think differently I've found.... You just sort of get caught up in it. It's a different atmosphere completely.... It's fun. But it's also kind of scary in that I think I've, being here you almost lower your goals or something... you get into a different frame of mind. Sort of. I guess if you're going to stay here then you don't need to keep in contact. But if you're going to go home you have to remember what it's like there.

The sharp differentiation of living experiences enhances the opportunity to view a summer living in Jasper as a time to become one of the crowd. Heightening this sharp demarcation of life back home from life in Jasper is the prime raison d'être for Jasper: a tourist Mecca. Millions of tourists travel to Jasper to escape their own routines. They come to Jasper for vacation.

Perceived Social Risks

Managing perceived social risks when dealing with health, illness, or injury conditions (subsequently called health conditions) is the central dimension or perspective that emerged from data analysis. Decisions made by Jasper's ASP/SP members to handle health conditions independently, or to access local formal and informal health care resources is predicated on the selection of strategies that manage perceived social risk.

There are two types of perceived social risk consequences that have been identified in the data analysis: threat to preservation of social standing within or acceptance by one's peer group (peer risk), and threat to preservation of the esteem of employers that is a means of job protection (job risk). Preserving social standing within one's peer group refers to avoiding the loss of, or incurring jeopardy to, esteem held by one's peers (SP members). Esteem within one's peer group is maintained or protected in order to sustain relationships with peer group members. Job risk refers to potentially jeopardizing one's employment as a result of managing a health or illness condition. An associated type of risk, less dominant in the perceptions of the respondents, is the health risk for the ASP/SP members and their peers. This health risk arises from failure to treat health conditions.

An overview of the analysis of the perspective of social risk in relation to the components of the dimensional analysis matrix is given as an introduction to the findings. The structure of the DA matrix is presented in Table 3 with an overview of the key dimensions arising from this analysis.

Table 3

Overview of Analysis

Perspective: Controlling Perceived Social Risks

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Stable SP characteristics	Barriers to action	Strategies to control risk	Risks avoided or incurred

Differentiating the elements that influence selection of strategies into these dimensions was the heart of this analysis. These elements were extracted from data elicited in open ended questions posed to respondents in group and individual interviews. In short, there were no questions asked of the respondents that would specifically address the categories within the DA matrix. The process of examining and analyzing the elements of respondents' stories and replies in light of Schatzman's question "What all is going on here?" lead to the differentiating of these elements into DA matrix categories.

In-depth discussion of the attributes of the health condition, the general SP context, and the conditions influencing their strategy selection follows. Examples of each dimension are given. The convergence of these three dimensions lead to the selection of a health condition management strategy by ASP/SP members. The remaining two categories in the Dimensional Analysis matrix, Actions (strategies selection) and Consequences (social and health risks), are discussed more fully in a subsequent section on strategies. In the present discussion, dimensions contributing to strategy selection will be described in relation to the characteristics of the sample. Biographical data sheets and group and individual interviews provided the data used in the analyses producing the DA matrix.

Issues categorized in the dimension labeled Context are given for all SP members. Examples include their age, short-term residence, and low paying jobs. Perception of social risk is triggered by the Attributes of the presenting health condition. The category of dimensions, which "facilitate, block or shape" (Kools et al., 1996, p. 318) the action taken are called Conditions. In this study, Conditions include fear of confidentiality and anonymity transgressions in a small town and perceived barriers, both social and logistical, to accessing local formal health services (Table 4).

Table 4

Dimensions Contributing to SP Strategies Selection

Attributes	Context	Conditions
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions
Stigmatizing Minor	Inexperienced in independent living	Cues from peers regarding the health condition
Unquestionable non-stigmatizing	Separated from family and friends	Social Barriers Cues from peers regarding the local formal health services
	Living in a small community	SP attitude towards local social/health care providers
	Transient residents	Employers attitude towards taking time from work
	Have low paying jobs	Logistical barriers
		Time constraints
		Financial constraints
		Visibility of local formal health services
		Poor understanding of how to access local formal services

It is noteworthy that health conditions perceived to be stigmatizing differ from other health conditions. Stigmatizing health conditions that threaten peer relations are associated with actual or potential sexual health conditions. Such health conditions could interfere with intimacy or personal relationships among ASP/SP members. The specific health condition perceived as a source of stigma from employers was alcoholism. Health conditions related to excessive alcohol use potentially compromised the employer/employee relationship. This is discussed in relation to job risk.

Strategies to Control Perceived Social Risk

Concurrent with the selection of the best strategy to address a health, condition, ASP/SP members manage perceived social risks by actively deciding the course of action least likely to jeopardize their social standing with their peers or to jeopardize their jobs. Three categories of strategies emerged from data analysis: Avoiding Perceived Social Risk Strategies (Avoiding Strategies), Minimizing Perceived Social Risk Strategies (Minimizing Strategies), and Embracing Perceived Social Risk Strategies (Embracing Strategies). These categories and their respective strategies are depicted in Table 5. Exemplars from the data accompany the discussion of the varied strategies.

Table 5

Categories of strategies to control perceived social risks

Avoiding Perceived Social Risk	Minimizing Perceived Social Risk	Embracing Perceived Social Risk
Ignoring the condition	Providing self care for the condition	Accessing local formal health services
Avoiding local formal health services	Accessing local informal health resources	

Dimensions Contributing to SP Strategy Selection: Attributes

The Nature of the Health Condition. The nature of the health condition for which intervention is sought influences ASP/SP members' choice of strategy. The existence of a condition precipitates the need for ASP/SP members to select a strategy to simultaneously attend to the health condition (physical or emotional) and to control perceived social risk. In this analysis, health conditions have been divided into three types: stigmatizing conditions; minor conditions; and unquestionable, non-stigmatizing conditions. Overt or tacit cues from peers drive the categorization of conditions into these three categories.

Stigmatizing Conditions.

Some conditions are perceived to be potentially stigmatizing and, as such, threaten peer relationships or their jobs. In this study, more data was accrued on the topic of jeopardizing peer relations than jeopardizing jobs. Health conditions in the stigmatizing category are associated , primarily, with sexual health and alcoholism.

Threats to Peer Relations. Sexual health issues are perceived to have a powerful effect on ASP/SP members' personal lives. As indicated in the discussions with ASP, SP, NSP, and Other informants, SP members receive tacit and open cues from peers that some sexual health conditions are potentially stigmatizing. For example, if a SP member's condition involves a sexually transmitted disease (STD) or pregnancy, this is perceived as a potential threat to peer relationships. A STD would potentially compromise dating, partying, or other activities shared with peers. Partying and social interaction was identified as a priority for many ASP members. Many ASP informants stated that their reason for coming to work in Jasper was to engage in partying. NSP and Other informants also believe that partying is a primary reason that many young adults are drawn to Jasper to work temporarily in seasonal positions.

If an ASP/SP member has or believes he/she has a sexual health condition, he/she may choose strategies to control this threat rather than the condition, potentially at the risk of personal health and health of others in their social community. To illustrate, one may choose an Avoiding Strategy and ignore the condition or avoid local formal services (detailed discussion of strategies is given in a subsequent section). If either of these strategies is chosen, the ASP/SP member does not receive appropriate assessment and/or intervention for the health condition. If this condition is a STD, both the individual and any potential sexual partners are at risk.

Among the sexual health conditions that destabilize SP members, pregnancy is notable. Pregnancy or fear of pregnancy appears to be particularly overwhelming to ASP/SP members. One Other informant commented on both the perceived gravity and interference with sound decision making caused by pregnancy.

> And it's interesting that it's still pregnancy that's much more frightening to them than anything else...[more than] AIDS or STDs. You kind of have to remind them that whoa, you know, once you've got the morning after pill. You make sure you get tested for the STDs and in a couple of months for AIDS as well. Because they don't, that's not even, the first thing on their mind

> is being pregnant. So that kind of shows to you like, it's still a very adolescent attitude. And even though they might be using the condoms, they might be saying that too. Like you can't, you don't know if they really are..... Because condoms don't really break that often unless you do something completely wrong. Or they might just say that so they kind of sound responsible when they're phoning the health professional or whatever.

Selecting risk negating strategies to manage this condition and controlling perceived social risk places the ASP/SP member at risk for physical and emotional consequences. Selection of an Avoiding Strategy such as ignoring the condition or avoiding services precludes timely assessment and/or intervention for the stigmatizing health condition.

Job Risk: Stigmatizing Conditions as Threats to Employment. Managing perceived risk to their jobs is also associated with ASP/SP members' choice of strategies. ASP/SP informants alluded to perceived risks pertaining to their jobs associated with both taking time off from work and ramifications from accessing certain local formal health services for a particular stigmatizing condition. One respondent alluded to the employer's dislike of workers taking time off from work for such appointments in the following way:

> A lot of people don't want to take, my friends anyway, don't want to take time off work. And also with, I know at the place where I work well, they're not always the best employers and they're not big on taking time off for, you know being, the hours to see a doctor or through the day when we're working....

During the second focus group, two notable points associated with absenteeism from work were raised. Respondents alluded to their expendable nature as employees and their precarious hold over their jobs. In this discussion, group members cited the number of other young people willing and waiting to take over their jobs.

> Lois: You are screwed if you take time off work.
>
> I: What happens if you take time off?
>
> Cheryl: Well, first you're fired. People are dropping applications off daily. They can....
>
> Tom: There's so many people out there looking for work.
>
> Cheryl: Oh, it's unreal.
>
> Tom: You are just a number.

Later in this discussion, another member of the second focus group described receiving a particularly strenuous work schedule following a one week absence to go home. She stated that she believed that receiving this particular schedule was directly related to having taken off time from her job.

> Lois: I just took 5 days off so I could go home.
>
> Cheryl: Have you looked at your schedule lately?
>
> Lois: And I've been scheduled for 9 days in a row, now.... It's because I took 5 days at the same time around when 8 people just quit.

Threats to job: The many faces of alcohol consumption. Alcohol related issues is the only potentially job threatening condition that SP members identified. Respondents did not identify alcohol consumption as a jeopardizing factor in peer relationships. In Focus Group 2, alcohol consumption was discussed at great length. During these discussions, two poignant insights regarding the ASP/SP and alcohol emerged.

First, the quantity and frequency of alcohol consumption by many ASP/SP members was suggested. Over the course of the 90 minute discussion with this group, three of the six focus group members mentioned that they believed that they had a serious problem with alcohol. Two of the members had discussed this issue and mused about attending Alcoholics Anonymous (AA) meetings. The third informant, admitting to a problem with alcohol, introduced the potentially stigmatizing effect of alcohol problems with employers. Specifically, he mentioned the anticipated difficulty in keeping a job if an employer were to learn that he or other ASP/SP members were attending AA meetings. This informant was atypical for the rest of the focus group because of his age, 24 years. Other group members were 18 to 22 years old.

These three admissions occurred at two separate times during the focus group. The admissions seemed genuine and not an artifact of group process or grandstanding. The impact of their statements became clear during transcript analysis: 50% of this group verbalized concern that they had a serious problem with alcohol. This group also believed attending AA meetings as an intervention for this condition would have severe, negative consequences. One of these consequences would be the stigmatizing among the townspeople with whom they interacted regularly. Secondly, the 24-year-old respondent who identified himself as having a serious problem with alcohol indicated uncertainty that he could remain “on the wagon”. He indicates that to be seen drunk after attending AA meetings in a small town would be awkward. The third and most salient consequence of attending AA meetings in Jasper was that it might jeopardize one's ability to hold a job in Jasper.

Minor Conditions.

The category of minor conditions includes common physical and emotional disturbances such as colds, the flu, minor sprains and trauma, and homesickness. Little data was collected on cues received from peers regarding minor conditions. SP members may select Avoiding, Minimizing, or Embracing Strategies for the management of minor conditions. Analysis indicates utilization of all three of these.

To illustrate, some SP members use an Avoiding Strategy: they ignore minor conditions and carry on or ride it out. Some SP members use a Minimizing Strategy and engage in self care, including rest and taking vitamins. Demonstrating a variation on the self care strategy, other respondents report using over the counter (OTC) preparations on their own accord or after consulting with pharmacy personnel. Accounts of ASP/SP members using an Embracing Strategy and accessing local formal health services for colds were also received from SP and NSP respondents. The reasons for the latter case varied. One NSP informant indicated that some ASP/SP members accessed local medical services for colds and flu because, as young adults with minimal experience in independent living experience, they did not have adequate self care skills to manage these conditions.

> ...But [they] also don't have a lot of skills and/or confidence in seeking help. I would expect that a quarter, maybe a third of the

> time, I'm actually playing mom or grandma or whatever. But I see a lot of late teens, early twenties with colds and flus that probably if they were at home would just be, you know, tucked into bed by mom and taken care of..... And this is often their first experience away from home. And so they don't know what else to do. So they wander by.

The following excerpt relates a scenario where a SP respondent believes a friend sought medical services for an allegedly minor laceration. This informant believed that the true impetus for this visit to the local physician was for reassurance and attention:

> Do you know something? I noticed though, with my one friend. I noticed she went to the doctor. She had fallen on her knee and it was cut. And it was a little bit infected. But it wasn't that infected. It was, I wouldn't have gone to the doctor for sure. But she went. And you know what I think it was is more like she needed that attention. Do you know what I mean? She was maybe a bit homesick. Or, you know how that is?

This final excerpt describes a local physician's thoughts on ASP/SP members accessing his services when the underlying reason for the visit may be homesickness:

> I think a lot of times it's just to get that reassurance that they're OK. Cause when you sort of look into the background of the cold or whatever it's not all that bad. And they seem to feel a whole bunch better once they've left. And so yeah, no I think that is a big issue. And particularly when you look at places like the Lodge that recruit from so far away. And culturally, of course, the Maritimes tends to be very community oriented and very family oriented, or at least, I haven't been there for a few years but that's my impression still. And here you have these young kids who have not been further away than a hundred miles from home and suddenly Jasper, Alberta. Stuck in a dormitory at JPL with all of these issues and things and no one to bounce things off.

Another respondent related a third motivation for ASP/SP members to seek local formal health services for minor conditions. This motive is to be excused from work. One informant describes an opportunistic strategy to access formal health services. If any SP member is seen for medical intervention and receives an official note, he/she is excused from working. The doctor's note validates absence from work and protects the ASP/SP member's job.

> ...Um, I find a lot of them [ASP/SP] they will go to the doctor right away. If, I think in some cases they just go to the doctor and get that note and then they kind of get off from work for a while.

Unquestionable, Non-stigmatizing Conditions.

In this study, a third category of health conditions was described. Originally called non-minor, non-stigmatizing conditions, this name was changed during validation interviews when an informant offered 'unquestionable' as a more suitable title for this category. Examples of unquestionable, non-stigmatizing conditions reported in this study include a seizure disorder, blood drawn for a follow-up lab test, sprained limbs, facial lacerations, dermatologic infections, an infection of unknown etiology, an acute episode of asthma, severe abdominal pain of unknown etiology, and alcohol poisoning. It is inferred that cues from peers indicate that these conditions are not perceived as threatening to peer relationships. Further it seems that peers deem professional intervention for these conditions appropriate and necessary. ASP/SP respondents describe seeking local formal health services for all of these conditions and freely discussing these conditions with friends. In Focus Group 1, one ASP respondent discussed her seizure disorder freely. Also during this group, friends of this informant discussed assisting her in managing sequlae from seizure episodes (facial lacerations) and arranging transportation to the local hospital for professional intervention.

ASP/SP and NSP informants described other situations where friends of ASP/SP members accompanied persons with unquestionable conditions to the Emergency Room for treatment or called an ambulance to transport them to the hospital. These latter conditions precipitated fear for the ASP/SP member and their friend(s), indicated potential imminent danger for the individual and/or were characterized by acute, severe pain.

Dimensions Contributing to SP Strategies Selection: Conditions Perceived Threats to Confidentiality and Anonymity

One of the most salient issues influencing SP strategy selection is perceived threats to confidentiality and anonymity. SP informants described being concerned about potential rejection by peers that might ensue after direct knowledge of having a stigmatizing condition became known or through speculation that one might have a stigmatizing condition. ASP/SP respondents express concern that confidentiality and anonymity could not be guaranteed in a small town such as Jasper. Therefore, in an indirect manner, accessing formal health services may precipitate a social risk for the ASP/SP that could jeopardize his/her relationship with peers. For example, analysis indicates that due to the small size of the town, it is possible that one's anonymity will be compromised if one is observed by peers entering a formal health service site such as a physician's office, health unit, or hospital. This peer observation may lead to questions or unfounded speculation as to the nature of the condition precipitating the visit. ASP/SP informants stated that if an ASP/SP member was perceived to have certain conditions such as STDs, the potential of this member to engage in social relationships might be compromised. It was for this reason that during an individual interview, a SP informant speculated that a mobile sexual health clinic held at JPL one summer was not successful. This respondent stated that summer workers did not want to be seen entering the room assigned once a month for the clinic. The location of the clinic room rotated as often as possible during the summer so that one location would not be uniformly identified with the sexual health clinic. Even when the room (door) was not labeled and information on the location of the clinic was discreetly made available, reluctance to take the chance of being associated with seeking intervention for a sexual health condition prevented attendance at the clinic.

Another speculation that erodes ASP/SP confidence in confidentiality and anonymity being preserved if local formal health services are accessed involves health service personnel. Respondents described a perceived threat to confidentiality that would result from accessing local formal health services. This is based on the perception that, if formal health services are accessed, persons working in the professional office may divulge information about a given ASP/SP member's health or illness condition. Due to the small size of the town, it is perceived that such news would travel quickly in the community. This perceived threat to confidentiality underlies the impetus to control a potential risk that could jeopardize relationships with peers.

Seeking to control this factor influences the choice of strategies selected by ASP/SP members to manage conditions. In the following excerpt, a SP respondent describes the strategy of leaving town to secure an abortion. The reason given for seeking services out of Jasper is the perception that health care personnel in Jasper may not maintain patient confidentiality:

> I had a friend who went on a long time about that. She went to Hinton for, I think she was pregnant and she went there to get rid of it. They don't go here. And I think the reason why they don't go here, they'll even just register at the doctor's office using hotel names. And I think that's what it is when it comes to pregnancy and the diseases and stuff. Because no matter who you tell, even if it's your totally best friend who promises he won't tell, it goes. Cause it's probably from the nurse or the doctor.

Similarly, the following quote suggests that NSP informants are aware of the potential confidentiality breaches:

> I think maybe they'd be more afraid of the confidentiality, would be my impression then for that. Because we don't see, like I would assume that a lot of them do go to the clinics. Because we (in the Emergency Room) don't see lots but I know that, you know, it's [sexual health/illness conditions] always been kind of a high risk area....Well I would think maybe it's confidentiality that they're concerned with then. And I think that people find things out, not through the hospital or the clinics. It's through friends and everything else.... I mean news travels before I even know it's going.

Perceived Barriers to Accessing Local Formal Health Services

Perceived social and logistical barriers to accessing local formal health services influence the selection of strategies. Logistical barriers include time constraints, financial constraints, visibility of local formal health services and poor understanding of the mechanisms to access local formal health services. Perceived social barriers include attitude towards local providers and attitude of employers towards taking time from work to access services

Perceived logistical barriers to accessing local formal health services:

Time constraints. Two overt time constraints are reported by ASP/SP informants. These interconnected constraints are issues of availability. Specifically, they are the limited hours of availability of local health professionals and conflict between ASP/SP working hours and time of availability of health care professionals.

The number of health care and social service providers in Jasper and their hours of availability is limited. The potential incompatibility of these professionals' hours of availability and the shifts worked by the ASP/SP is central to this constraint. To illustrate, local medical services will be explored. Jasper has three full -time physicians who have individual or group practices in town. These three physicians also comprise the medical staff for the local hospital and Emergency Room. During the summer, the Emergency Room provides services for many of the large number of tourists visiting Jasper. The physicians' time is spread across these practice sites for year-round coverage. Frequently, the hours of availability for these medical providers are a poor match with the hours when ASP/SP members can access the required service.

To access local formal health services, ASP/SP members often must take time off from work. The constraining nature of this potential incompatibility between health and social service availability and ASP/SP non work hours is heightened by another barrier--employer policy/attitude towards time off for accessing services. This was discussed previously.

Financial constraints. ASP/SP informants mentioned financial hardship as one barrier to accessing formal health services. Therefore, if accessing formal health services will entail fees, some ASP/SP earning less money may choose not to access these services. These financial constraints reinforce the choice of Risk Avoiding Strategies.

Most ASP/SP members work for minimum wage. Gratuities and tips from customers are inconsistent in frequency and dollar amount. Some positions, such as housekeeper, receive relatively small tips although the work done by these persons is strenuous. Other positions such as waitress or bartender tend to receive more tips. Tips also vary according to the worksite. Tips at the Jasper Park Lodge tend to be larger than at some of Jasper's townsite hotels.

Three examples of financial constraint were reported in this study. These examples include issues of eligibility for Alberta Health Insurance Program (AHIP) coverage, loss of wages, and the financial burden of prescribed medications. These examples are discussed below.

Firstly, ASP/SP members who originate in other provinces are not immediately eligible for AHIP coverage. Such persons who have come from out-of-province are financially responsible for any visits to professionals in the local formal health services for up to 3 months. Although they may be subsequently reimbursed at the rate of coverage provided in their home province, the need for immediate outlay of money is a problem. This lack of coverage and resultant financial responsibility acts as a deterrent to visits to physicians' offices and engenders negative attitudes towards local providers.

The following excerpt demonstrates a lack of knowledge regarding acquiring AHIP coverage that acts as a barrier to access for ASP/SP members:

> It's just kind of a pain in that I don't, like you say as far as getting covered with health insurance and stuff like that. I'm not sure how that works so I'd rather avoid the problem of trying to figure out how to do it. You know that kind of thing. Or I'd probably call my mom and ask her if I should go....

Two informants indicated that they were experiencing financial barriers to accessing Jasper's services associated with lack of AHIP coverage. The following excerpts demonstrate these situations:

> Myself, probably not right away. I'm usually, like I'll leave it until I'm like deathly ill before I actually will go in to have something checked out...Yes, just because I am not covered under medical insurance right now or anything so it would really have to be serious for me to go in....

> But a lot of them I've seen just kind of stick it out. They don't really bother to go to a doctor. They might just go to the drug store and get something but they don't really bother to go see the doctor. Because again if you don't have any coverage you have to pay for your visit as well.

Secondly, ASP/SP informants alluded to reluctance to lose wages related to taking time off from work. This is indicated in the following excerpt:

> Yeah, it's um, well with a lot of people here just because there's not a lot of doctors it's hard for people to go. Like they, and they don't want to take time off work often because it's hard enough as it is to save money. So I've noticed that a lot of people don't want to take, my friends anyway, don't want to take time off work.

Thirdly, if a medication is prescribed, ASP/SP informants indicated that they frequently do not have the money to pay for the medication. This excerpt demonstrates a further financial barrier to accessing local health services. In this section, respondents describe the inability of an ASP/SP member to afford prescribed medications. A sense of futility in accessing the services is apparent in the voices of the informants:

> Lois: Well when Richard got really sick, he went to the doctor and she just give him a note saying he can't work any more for a week and gave him antibiotics.
>
> Tom: Yeah that's another thing, you can't afford to be sick....
>
> Lois: Oh I know, like I was at the doctor and they said to me, I had some sort of, some sort of infection and he's like writing a prescription. Like I can't buy a prescription, it's like, oh it's really cheap, it's only like $12 or $13. I had like 17, 18 cents to my name, you know. There's no way....

Visibility of local health services. The following excerpts demonstrate how a lack of knowledge about the location of formal health services also acts as a barrier to ASP/SP members. The first comment is from a focus group member and the second from one of the SP individual respondents:

> That's weird too because like now that the subject comes up, I don't even know where the doctor's office is.
>
> ... like I have no idea about the, I'm not sure where the health clinic is or that kind of thing. Or what, you know, like here I am with a sore throat and sore ear and I'm not really sure where to go.

Poor understanding of accessing local health services. ASP/SP informants mentioned uncertainty in the mechanism to access Jasper's health services. This is in spite of the efforts of Jasper's Family and Community Social Services (FCSS) agency. FCSS produces an orientation package for SP members called the Survival Kit. The Survival Kit provides guidance for accessing many local and provincial services and other useful information. These packages are distributed through employers. Further exploration of the effectiveness of this distribution mechanism and the SP's utilization of this orientation package is warranted.

The following excerpt indicates a respondent's uncertainty in accessing local services:

> Yeah, yeah it was. But yeah, the summer workers I don't think we're informed too much. We don't know really where to go, you know, either. Maybe if you lived here you'd have a better idea with connections or something.

Social barriers to accessing local formal health services. Social barriers constrain the access to local formal health services by ASP/SP respondents. These social barriers include the employers' attitude towards taking time off from work and the ASP/SP attitude regarding local health providers. In the following excerpt, a SP informant mentions potential employer displeasure with ASP/SP members for taking time off from work to go to an appointment:

> And also with, I know at the [place where I work] well, they're not always the best employers and they're not big on taking time off for, you know being, the hours to see a doctor or through the day when we're working.

The following excerpt demonstrates one SP respondent's attitude towards local health care providers as a barrier to accessing local formal health services:

> I think a lot of summer staff when they're just here for the summer, they just, the less they see of a new doctor and trying to get that kind of a, what's the word? Just friendly...
>
> I: A rapport?
>
> Yeah. Yeah, exactly. Just trying to feel confident with the new person, I think it's, a lot people just think it's a waste of time really. If you're just here for a couple of months.

The following is an excerpt demonstrating lack of confidence in local health care personnel as a barrier to accessing local health services.

> But I said to her I think you should just go to get checked out anyway because lately she's been kind of sick, kind of run down and she goes to this doctor in town and she doesn't like him....And I said to her, I said you should go see Dr. Black. I said I find he's the best that I've ever been to. I've been to a few of the doctors and I suggest you should go see him. But I don't think she likes doctors very much at all.

Risk Managing Strategies

Strategies to Avoid Perceived Social Risk

Maximal control of perceived social risk is achieved by implementing an Avoiding Strategy. The temporary nature of residing in Jasper for a summer season underpins the viability of the Avoiding Strategies. Health conditions may be ignored for a few months if need be. Professional intervention may be sought at the end of the summer. The two strategies in this category are ignoring the condition and avoiding local formal health services.

Ignoring the condition. The first Avoiding Strategy is ignoring the condition. ASP/SP informants reported that most conditions that are ignored are minor illness conditions such as colds or flu. Exceptions to this exist. Motivation for these exceptions is discussed later.

By ignoring the condition, an ASP/SP member does not seek local formal health services. In this way, ASP/SP members exert maximum control over any potential social risk with peer relationships or their jobs. That is, the ASP/SP member risks neither being seen entering local formal health service facilities nor the perceived possibility that information about this visit will become known in the community. Further, since no time is taken off from work to go to an appointment in the formal health service, social risk associated with an ASP/SP member's job is, again, minimized and control over this job-related risk is maximized.

Three of the four respondents who reported the strategy to ignore minor conditions were male. The only woman reporting this strategy, 20-year-old Cheryl, from Focus Group 2 was returning to Jasper for summer employment as a housekeeper and reported that she has a seizure disorder. It is unclear if the experience of managing a significant condition such as a seizure disorder influenced her decision to ignore minor conditions such as colds or the flu. Cheryl and one of the other male focus group informants mentioned below also suggested using self care as a strategy for managing minor conditions.

Following a description of this strategy by other informants are comments on ignoring or riding out minor illnesses from four respondents. Three of these respondents were from the second focus group.

The male focus group members included Kevin, a 19-year-old and Tom, a 24-year-old. Both these informants were working in Jasper for the first time. Both had full time jobs as housekeeping staff in hotels although Tom also held a second part time job waiting tables in a bar. In addition, one male SP informant who was interviewed individually described ignoring minor conditions as a strategy. Jack was a 21-year-old male working for the first time in Jasper as a full-time gardener at Jasper Park Lodge. Their comments on this strategy are presented in context. Other strategies which are discussed later appear in this excerpt as well.

The first two excerpts are from Focus Group 2. The first excerpt is a response to a general inquiry about management strategies for conditions. The second excerpt, although similar, is a response to a more focused inquiry on managing minor conditions:

> I: If you do feel poorly, what do you do? What are your options?
>
> Kevin: Ride it out.
>
> Tom: Sleep more.

> Lois: I just went back home and I just waited until I went back home. I got my mum to phone my doctor in Kelowna because I'd just rather have gone there....
>
> Kevin: Ride it out.
>
> Alice: Vitamin C.
>
> Cheryl: Vitamin C, yeah.
>
> Tom: Buy the pep pill.
>
> Cheryl: Just ride it out.

The following excerpt, from Jack, succinctly demonstrates the strategy of ignoring the condition:

> It's just, I have a cold and I need to get through it and it'll be all gone in a week and you just live with it.

The following excerpt is not a straightforward exemplar of the ignoring the condition strategy. This informant initially decided to ignore her ear pain. Next, she mentioned that she might consider seeking medical treatment for her condition as the pain began to intensify. Presence of significant pain, usually associated with unquestionable conditions, is one of the differentiating characteristics among the three different types of health conditions in this study. The logistics of this informant's job aggravated her ear pain. At the time of the interview, she was an operator of the tramway that ascends Whistler Mountain. At the end of the excerpt, she once again supported the strategy to ignore the condition:

> My ear, I probably wouldn't go to the doctor. Well, I might cause it is getting sore now. But especially I'll probably go now because it really hurts a lot with like going up and down in elevation or whatever. But I can see that just because I'm not at home I

> might not go see a doctor out here. Especially cause the end of summer is coming too and I figure I can wait until I get home.

In this final excerpt, Mark suggests that this strategy of ignoring the condition may be part of his modus operandi in managing conditions whether he is in Jasper or elsewhere:

> Yeah, boy, it'd have to be, I'm not really, I don't run to the doctor very often. I mean, you know, I sprain my ankle I'll go to the doctor, you know. Or I had a strep throat and I went to the doctor. But I mean if I'm not dying I pretty well won't go to the doctor.

Avoiding local formal health services. The second strategy by which social risk is negated is the avoidance of local formal health services. In selecting this strategy, ASP/SP members avoid negotiating perceived social risks and ultimately avoid stigma. The conditions for which ASP/SP members choose to avoid formal health services are catastrophic/terminal illnesses, sexual health/illness issues, and alcoholism.

Catastrophic/terminal conditions included cancer and AIDS. While AIDS is a sexual health condition, it has been placed in the category of catastrophic conditions because respondents mentioned AIDS in that context. When questions concerning sexual health were discussed with ASP respondents, AIDS was mentioned occasionally but was not categorized by informants with the frequently mentioned sexual health/illness conditions of pregnancy, fear of pregnancy, abortion, or STDs.

In the following excerpt from Focus Group 2, catastrophic illnesses in the context of avoiding local formal health services are discussed. Of note in this excerpt are references to dimensions that influence the actions of ASP/SP members. These dimensions from the category of Conditions in the Dimensional Analysis matrix include fear of breach of anonymity, fear of losing peer relationships due to the diagnosis becoming public knowledge, and an acknowledgment of the importance of peer relationships. This latter statement is linked with the facts that friends are all you have out in Jasper and that ASP and SP members are away from their family and support systems (friends) at home:

> I: Are there any other illnesses or health problems that might come up that you think people will wait until they go home to take care of?
>
> Tom : Cancer, diseases like that probably....
>
> Lois: Cancer?
>
> Alice: Yeah, if I thought I got cancer I wouldn't stay....
>
> Lois: AIDS, I wouldn't stay here, I'd go home.
>
> Tom: I'd leave.
>
> Cheryl: God, if you found out you had AIDS, the whole town would know in 15 minutes.
>
> Tom: That's why I'd leave....
>
> I: Do you have any sense why it is with some of these larger issues people will, you know, won't stay in Jasper, they'll take them home?
>
> Tom: Because they don't want everybody knowing.
>
> I: It's the knowing?
>
> Lois: So scared of losing your friends.
>
> Tom: Yeah, because that's all you've got out here really.

> Alice: If you have no friends, you don't really have anything. You're totally alone.
>
> Lois: Yeah, because your family is not here, so.
>
> Alice: If I had a disease like cancer or AIDS, I'd want to be with my family. I'd go home.

Negative cues from peers about health conditions cause these conditions to be perceived as stigmatizing. Stigmatizing conditions often include sexual health conditions. Cues from peers regarding the management of conditions within this strategy are twofold and interconnected. ASP/SP informants indicated that sexual health conditions may jeopardize one's relationship with peers. Also, respondents related a fear of breach of confidentiality and anonymity if one was to seek intervention for a sexual health condition at local formal health services. In the case of implementing Avoiding Strategies, the perceived social risks appear more weighty than physical risks to the individual member of the ASP/SP community.

Focus Group 2's discussions provided much information on managing stigmatizing conditions. Alice stated that she would not have an abortion in Jasper. This declaration was accompanied by the story of her friend who had had an abortion in Jasper. Fear that information about having an abortion would spread quickly in the small town of Jasper is the primary reason stated for not having an abortion there:

> Alice: I wouldn't get an abortion in this town.

> Lois : No, I know someone that did.
>
> Alice: Yeah, me too.
>
> I: What happened?
>
> Alice: She was just, I don't know, she was French. She went down to Seaton [Hospital] and got the abortion and she was having big stomach pains and this and this, and this. And then she had to go on all these antibiotics afterwards that she couldn't afford. It was just horrible. I felt so sorry for her. She was all alone and she had no-one. She had no family, she had nothing. And it's such a small town. People talk....
>
> Cheryl: Oh God, people would find it out like that.
>
> Alice: That same day and they just, they're mean. Just don't care.

In the following excerpts, SP informants describe situations in which they would not access formal health services. In the first excerpt, an informant suggests other dimensions that act as barriers constraining access to some local formal health services. These barriers are a lack of confidence in or comfort with local health care providers and the fear of loss of confidentiality and anonymity.

The following excerpt demonstrates an avoidance of accessing local formal services for a sexual health condition due to fear of loss of confidentiality. The excerpt is from an individual interview with Agnes. A pivotal facet introduced in the second of these excerpts is a perception that the source of information leaking into the community is perceived to be the health care providers themselves:

> I had a friend who went on a long time about that. She went to Hinton for, I think she was pregnant and she went there to get rid of it. They don't go here. And I think the reason why they

> don't go here, they'll even just register at the doctor's office using hotel names. And I think that's what it is when it comes to pregnancy and the diseases and stuff. Because no matter who you tell, even if it's your totally best friend who promises he won't tell, it goes. Cause it's probably from the nurse or the doctor.

ASP/SP informants were not uniform in their response to managing sexual health/illness conditions. A discussion in the second focus group demonstrates some of the divergent opinions among the respondents about accessing local formal health services for issues related to sexual health. Of note is the potential gender split on this discussion. Tom advocated seeking intervention for a STD and informing sexual partners that he/she may have been exposed. Since Tom was, at 24 years of age, an atypical (the oldest) ASP respondent, his responses may be colored by this difference in age and experience. Lois, one of the women in the group, immediately responded to Tom by telling him that that might be an easy course of action for him. It appeared that she did not share Tom's belief that these potentially stigmatizing conditions could be managed so openly.

> I: What I'm hearing is that people will go home or wait till they go home for things like sexually transmitted diseases and pregnancy. That just goes on hold until I can get out of Jasper.
>
> Lois: Oh definitely.
>
> Tom: Ah, ah. No way, [I'm] taking care of that right away. That's not going to wait....
>
> Lois: I'd wait till I went home to see my own doctor, like.
>
> Tom: No.
>
> Lois: Yeah.

Tom: A doctor is a doctor. You get a problem, get it taken care of. Sexually transmitted diseases and stuff like that, you got to, like there's no pride behind that. You got to just take it, get it taken care of, for crying out loud.

Lois: That's easy for you to say, like.

Tom: Oh I don't care. I'd just go right away, there, get it done.

I: Why do you think it's different?

Lois: Well because, I just know that you can't say "oh, I'm not going. I'm just going to swallow my pride and let all Jasper know that I have some disease." Like you don't want that to happen.

Tom: You don't have to tell nobody but one doctor.

Cheryl: Yeah, but it's not that easy. People will find out.

Tom: How are they going to find out...?

Lois: You have to tell, like some girl who you had sex with and then she has to tell....

Cheryl: Then she's going to know. It just goes on like this.

Lois: Tom, you have to tell someone if you get a sexual.... You have to tell.

Tom: Oh yeah.

Lois: You have to tell the people you've had sex with.

Tom: Oh yeah, for sure.

Lois: Then they'll tell someone and then they'll tell someone and then they'll tell someone.

Cheryl: And they'll tell two friends and they'll tell two friends, and they'll tell two friends.

Tom: No, but you guys are like crazy. That's craziness. No, I'd go right up to them. I would just like, hey, you know, you gave me a little bit more of a special time than I was looking for. We got to talk about this, get this fixed up. Because you know, you're

> endangering other people you know, because they might go out and have sex with other people and you, for sure, are going to go out and have sex with other people....
>
> Lois: And you transmit it.
>
> Tom: You got to get that taken care of or you're endangering other people other than just yourself.

The following excerpt from Cheryl, a member of Focus Group 2, demonstrates a fear of losing confidentiality and anonymity as a result of accessing local formal health care services. Cheryl had previously described a long-standing relationship with a health care provider in Jasper to co-manage her seizure disorder. In this excerpt, Cheryl refers to the challenge of maintaining confidentiality in either the physician's office or in accessing the local distress line. She equates this challenge directly with the small size of the town of Jasper, referring to the 3000 permanent residents. (This number doubles to 5-6000 when summer employees move to Jasper for the high tourist season.):

> Cheryl: I was in Dr. Smith's office the other day and it's like the distress line... which is Jasper's, Jasper's connection and I'm not going to phone someone here and tell them my life problems when there's only 3,000 people living in the town. People are going to find out about it. There's no way.

Choosing an Avoiding Strategy: The role of alcohol. SP informants identified another instance in which they would not access local formal services. This formal service was Alcoholics Anonymous (AA). Loss of confidentiality and anonymity related to alcoholism were at the basis of this example. The feared consequence was not loss of peer support or social standing as in the case of sexual health issues. In the case of avoiding AA, the SP informants indicated that they felt that their jobs would be in jeopardy if their employers knew that they were attending AA meetings. The following excerpt exemplifies this concern:

> Tom: Like I had thought about going to an AA meeting but I don't know if I could stay on the wagon, eh, and it's like if I go to an AA meeting and I meet all these people who are in AA and then if I fall off the wagon and they see me, I'm like going ah man.... They're looking down on me going, 'Geez, you drunk.' You know, its just too much stress.
>
> Cheryl: Here being an alcoholic is different.
>
> Tom: That and you [don't] have a really good chance at the jobs either. You know.
>
> Cheryl: Yeah, you'd have a problem finding a job if they find out you're in AA.

One of the NSP informants, a physician, reported that he has recently encountered this concern about alcohol usage among SP members. His comments follow:

> I: But certainly alcohol is a very prominent issue.
>
> Dr. Black: And almost more so than drugs, although there are drugs in this community.... Alcohol for me is primary. And I've seen, other than town kids that I've seen which is another issue, a number of alcohol poisoned late teen, early twenties in the last year. More so in the last year than I have in the last couple. And I've actually had a couple of people come to me because they were concerned that they were drinking too much. At the age of 20 or 21....

Of note in the above excerpt is that ASP/SP members have accessed physician(s) regarding a concern with alcohol, but previous commentary mentions a hesitation to seek help at AA. Another NSP informant who works with alcohol and other psychosocial issues reported that she sees a small number of SP members for counseling.

Data analysis indicated that strategies selected in regards to issues of sexual health are varied but frequently involve Avoiding Strategies. Exceptions to this are described in the following excerpt. The excerpt, from a local physician, describes a pattern of SP members, particularly women, who visit local formal health services for sexual health/illness conditions. Of note is the fact that preventive service such as birth control counseling is mentioned in this pattern. None of the ASP/SP respondents in this study discussed birth control counseling in the constellation of sexual health/illness conditions:

> Dr. Black: Yeah. So I mean and that's one of the, what we say is you sort of see them for their birth control pills in sort of April, May, June and then you start seeing them late June, July and August for their abortion. And I don't think this year was quite as dramatic, but you can see that happening through each summer.
>
> I: Roughly, without you know, trying to get specific on numbers, how many people do you think you see for birth control counseling and then maybe later on, not that they're the same groups, but you might see birth control counseling and later on how many abortions would there be in the summer?
>
> Dr. Black: Um, I would probably, in the height of the early part of the season, I could see at least one or two women a day for birth control. Um, which may not sound like a lot but when you've got a sort of a relatively busy practice that takes a lot of time if you're going to do a good job of it.
>
> I: Sure. Exactly.
>
> Dr. Black: And later in the season, um, probably two a week for abortions. One to four [per week] would probably be the range....

> And that would probably last for a month or two, you know for six weeks would be the sort of the busy peak.
>
> I: I've heard, I've had a little bit of response, but very spotty about requests for the morning-after pill. Do you ever get that?
>
> Dr. Black: Ah yeah, actually that's a good point. That would come in that other peak.
>
> I: Between the birth control and the abortions comes the morning-after pill.
>
> Dr. Black: Exactly, exactly. And that commonly, that's a little harder to track cause they often end up over at the hospital. That probably would only be sort of one or two a week for three or four weeks. And then sporadically any other times.

Strategies to Minimize Perceived Social Risk

The second category of strategies is designed to reduce or minimize perceived social risk. Strategies in this category include utilization of self care and accessing informal health resources in Jasper.

Utilization of Self Care. Self care refers to the actions undertaken by an individual to maintain his or her health, provide physical or emotional comfort, or relieve symptoms of illness without accessing available formal health services. Examples of self care in this study include talking with friends, self-imposed increase of rest, consumption of vitamins, and use of self-prescribed over the counter medications (OTC) such as cold preparations or NeoCitran. ASP and SP members utilize self care to primarily manage minor conditions. Data on peer cues related to implementation of self care is presently inadequate.

Since local formal health services are not sought in this strategy, the constraining dimensions/conditions, such as breaching confidentiality, are not called into play. Perceived social risk related to other peer relationships or employers associated with the self care strategy is low.

Self care was described by one focus group member and two individual informants. Alice, a member of Focus Group 2, described self care as a strategy in two passages of the Focus Group 2 session. At the time of the focus group, Alice was a 22-year-old female who worked full-time as a housekeeper in a hotel. She had been in Jasper for 24 continuous months. Alice's age and length of stay in Jasper made her atypical for the other Focus Group 2 members. Of note is the fact that the three informants who discuss self care are SP respondents and, therefore, slightly older that the average age of either focus group.

> Alice: Oh last New Year's I sprained my ankle pretty bad and I didn't work for a week. I just kept my foot up, that's all I did. I didn't even go see the doctor. I just put ice on it and a week later I started work again. I was limping a bit but that's OK.

Mark and Angie also described self care as a common strategy. Both Mark and Angie are in long-term relationships and live with their partners who also live in Jasper. Mark is a 26-year-old male, in Jasper for his first season, who works full time as a night auditor in a hotel. Angie is a 20 year-old female who works full -time as a hairdresser in a combination hairdressing/souvenir shop. Angie had been working in Jasper for 10 months at the time of the interview:

From the individual interviews, the following excerpts exemplify the utilization of self care:

> I: So what'll you do instead? What are your resources?
>
> Mark: Just, um, you know, go to the drug store and whatever kind of medication depending on what I have, headaches or the flu or whatever, I'll just pretty well try to look after it myself.

> Angie: I usually, medication doesn't really do anything. I get very sick and dizzy if I take even, like I just got over a cold. So when I had the flu on Wednesday, I'm usually really used to being sick because I used to be sick all the time at home with either the flu or just being sick with stress or like I had the Beijing Flu really bad last Christmas. And I was very sick for about 3 months. So, but I don't usually go to the doctor at all. I usually, if it's the flu or a cold. If I get really, really sick I'll go. But usually I don't go. I usually just have NeoCitran and wait it out.

Accessing local informal health resources. Accessing local informal health resources is one strategy in the category of Minimizing Perceived Social Risk. Local informal health resources include local health food stores and pharmacies. These establishments and the personnel who staff them are important resources for ASP and SP members. Local health food stores and the staff therein provide information on vitamins, various OTC preparations, and nutrition information. Local pharmacists provide advice regarding OTC medications, vitamins, pregnancy tests, etc.

Perceived social risk associated with the strategy of accessing local informal health resources is a mid-range risk. Social risk associated with this strategy is higher than that associated with ignoring the condition but lower than accessing local formal health services. In selecting this strategy, issues of confidentiality and anonymity are avoided. Control of this social risk associated with peer relations is also mid-range. It is lower than the strategy for self care because SP members can be seen going into pharmacies or health food stores. This occurs because these establishments have a raison d'être beyond providing health information and products. Therefore, there is less threat to social standing by being seen accessing these establishments.

Control of social risk associated with this strategy is higher than accessing local formal health services because ASP/SP members have some control over when this strategy is implemented. For example, they can decide to discuss their condition with peers and decide to seek local informal health resources. Further, they can decide to take the risk of accessing the establishments at a time when they may not be observed entering the premises. With informal health resource establishments, the hours of operation are less restrictive than with formal health services. Therefore, social risks associated with peer relations, especially those associated with being seen entering such an establishment, is under the control of the ASP/SP. Control over the risks to the ASP/SP's job is also high for these same reasons, because the generic raison d'être of the pharmacy does not indicate to employers that an SP member may have a job-jeopardizing condition.

In the following excerpts, Agnes describes going to a local pharmacist for advice in managing an illness condition. Agnes is a 25-year-old female who has one full-time and one part-time job at the JPL. Agnes lives with her boyfriend in couples accommodation provided at JPL. She had worked in Jasper for almost 24 continuous months at the time of the interview. During this time, Agnes has worked both in the town of Jasper as a SP and at her present position at JPL. Agnes also alludes to self care as a management strategy :

> Agnes: Yeah. Well if it's like say if I start to feel the flu coming on or I just have cramps or something, I usually just go to the drug store first because I find to get an appointment with the doctor you usually don't get in until the next day. And say if it's in the afternoon you start to feel a bit sick you won't be able to see him until the next day for sure. So I just usually get some medication at the drug store or something. Just ask the pharmacist what would be best to help with it. And then if it still persists I will go to the doctor, but most of the time I don't go to the doctor if it's like the flu or something. I usually just take care of it myself. Unless I get really sick like that.

In this excerpt, Agnes relates the story of a friend who went to the local pharmacy for a pregnancy test. In this way, a potentially stigmatizing condition was managed with minimized perceived social risk. It is important to note, however, that the respondent in this story and others who utilize self care and informal health resources to manage physical conditions and control perceived social risks may have other concurrent conditions that require appropriate intervention from a formal health service. The ASP/SP member may not even be aware of these conditions let alone seek intervention for them. In this way, their own personal health and potentially the health of peers is placed in jeopardy:

> Agnes: ...I've seen a very close, a friend of mine she was pretty sure she might have been pregnant. But she wouldn't go check it out. She would not. And I kept saying, you have to get it checked out. But yeah, I see that one lots.
>
> I: So what did she do?

> Agnes: She finally, well she went to a drugstore and got one of those home pregnancy, the pharmacy had recommended this one because they said it was like 99% effective.

In the following excerpt Agnes, who has worked both in Jasper townsite and at Jasper Park Lodge, describes a combination of strategies in which she has seen ASP/SP members engage. This story is presented in the accessing local informal health resources strategy, although elements of ignoring the condition are present as well. Also notable in this excerpt is the financial constraint of lacking AHIP coverage:

> But a lot of them I've seen just kind of stick it out. They don't really bother to go to a doctor. They might just go to the drug store and get something, but they don't really bother to go see the doctor. Because again if you don't have any coverage, you have to pay for your visit as well.

Strategies to Engage Perceived Social Risk

Accessing local formal services. The fifth strategy employed by SP members is directly accessing local formal health services. Local formal health services in Jasper include formal services that provide intervention or education for health, illness, or social conditions. Examples include AADAC, Family and Community Social Services (FCSS), the local hospital or emergency room, physicians' offices, support groups for persons with a history of physical or emotional abuse, etc.

ASP/SP members seek local formal health services to manage minor health conditions, stigmatizing conditions, and unquestionable non-stigmatizing conditions. Positive or negative cues from peers regarding these conditions have been discussed. These cues are directed towards both the condition an ASP/SP member has and also towards accessing local formal health services.

ASP/SP informants inferred that some illnesses or injury conditions required attention by a health care or social service provider in the local formal health services. Further, these conditions did not have a high degree of social risk associated with them. These are unquestionable, non-stigmatizing conditions. The ASP and SP members discuss these conditions freely among themselves and do not appear to have concern that relationships with these friends will suffer as a result of the knowledge being shared. Examples of these scenarios are given below. SP and NSP informants indicate that some ASP/SP members seek formal health services for minor conditions and stigmatizing conditions as well. These situations will be discussed later.

These scenarios include management of a seizure disorder, receiving care for facial lacerations, treatment for a musculoskeletal injury to a knee, a migraine episode, and treatment for an unknown infectious process. In these scenarios, social risk regarding personal relationships is, technically, high because the ASP/SP member may be seen going to the formal health service facilities. The nature of the illness or injury condition, specifically being unquestionable, appears to have an impact on this, however. As noted in the excerpts, accessing treatments for a seizure disorder and migraine headaches are not seen as incurring a threat to social relationships. Peers were also supportive in facilitating these informants in receiving treatment for the migraine headache and for facial lacerations suffered secondary to falling on the sidewalk during a seizure.

In the following excerpt Karen, a member of the first focus group with a history of migraine headaches, describes both her reasoning in deciding to seek treatment for a migraine episode that occurred while she was in Jasper and the role of other ASP members in this decision. Karen is a 19-year-old female working in Jasper for the first time. She has one full-time job as a housekeeper. It is noteworthy that in spite of a history of migraine headaches and an understanding of the interventions that are effective for her, Karen did not bring her medication for migraines when she came to Jasper to work for the summer. In this excerpt, it appears that the ASP member suffering from the acute migraine episode was given permission by other ASP members to seek professional intervention for her headache:

> Leslie: Well like when you had your migraine, it was our friends who said, and you as well, it was a decision on, I think on all of our heads, OK, we'll take her to the hospital. So it wasn't just that one person making the decision.
>
> Karen: It was an avoidance of like, I didn't want to get any worse. Like you can probably live with it but might as well get rid of it.
>
> Leslie: Yeah.

In the following excerpts Cheryl, a respondent in the second focus group, discusses her seizure disorder, and then mentions her perceived need for both the local hospital and the local physician who had helped her manage the disorder over the two summer seasons that she had come to Jasper to work as an ASP member. After Cheryl's excerpts, Lois, a friend of

Cheryl's and another informant from the second focus group, discussed taking Cheryl to the local hospital. Lois was a 19-year-old female holding a full-time job as a housekeeper and a part-time job bussing tables in a restaurant. This was her first season working in Jasper as an ASP member.

> Cheryl: My brain is kind of screwed....Yeah, I have epilepsy so it's kind of screwed..... I've been, I've been really sick for the last 3 weeks. Like I've been having a lot of seizures over the summer. I had 3 in the last 3 weeks which usually I've had them, I used to have them like once a year, and I don't know what's, why, but I've just been getting, having them so much and I don't know what I'd do if the hospital wasn't there. Dr. Smith, I've had him for about 2 years and I totally trust him.
>
> I: So even though you are back and forth...?
>
> Cheryl: I keep Dr. Smith.
> I: He stays then? So you have continuity. Is that unusual, do you think?
>
> Cheryl: I don't know. With my health problem, like I need someone and he knows totally what's going on.

In the following excerpt, Lois discusses taking Cheryl to the Emergency Room after Cheryl had cut her face as a result of falling on the sidewalk during a seizure that had occurred earlier that summer:

> Lois: Plus when Cheryl hurt her face, she was bleeding everywhere and luckily the guy at the Jasper Inn across the street just gave us a ride to the hospital in his van or else I would have had to walk with Cheryl bleeding all over the place.

In the following excerpt, an SP informant describes a situation where a decision to access formal health services was made because symptoms were such that the SP peers were afraid for the ill member. In one scenario, Agnes's boyfriend called JPL security who subsequently called an ambulance for her. On this occasion, the informant developed apparently remarkable abdominal pain among other symptoms. Her boyfriend did not know what was wrong with her but surmised that professional intervention was needed. In this case of perceived need for professional intervention, as in the case of seizure disorder and the migraine headache episode, the decision to access local formal treatment was made for or in conjunction with the SP member who was ill.

In this scenario, Agnes describes an episode of sunstroke with presenting symptoms of acute severe abdominal pain and weakness:

> Agnes: [I]...was freezing at the same time. My boyfriend said I turned as white as that sheet. And he got, well, he got pretty scared cause he didn't know what was on the go. And he called security at JPL. And they called an ambulance. And the ambulance got there like 20 minutes after he called. And by then I was starting to come around a little bit.

In this scenario, Kelly describes the process of peer input guiding an ASP member to seek local formal health service intervention for a dermatologic infection on his leg:

> Kelly: So it's hard to, there was guy who had a big boil on his leg from something, maybe it was an ingrown hair or something, and he was limping around. It was really bad. And anyway nobody would take him to the doctor. And he didn't have any time to go. And it got really infected. And I don't know why he didn't go earlier. It was just too inconvenient for him. So, finally somebody drove him to the doctor like one day. Somebody said oh, you'd better go. Like that's ridiculous. So he didn't. Somebody else made him go though. It wasn't his decision. Well, I mean, he had the ultimate say I guess, but....

An unusual case: The long term, out of province SP informant. Alice was one of the SP informants who had lived in Jasper for several contiguous seasons. Alice did not meet the sampling criteria but who was not asked to leave the group due to a concern that excluding her would impact negatively on the general group process. Second, she was not originally from Alberta. Her home province was Quebec. These two factors may have influenced her decision to access local formal health services for a sexual health issue. Alice provided two stories of ASP/SP members accessing local formal health services for sexual health conditions. She reported using local formal health services to have a pregnancy test performed:

Alice: I only went to the hospital once. I had gray hairs.

I: What was that like?

Alice: It was just for a pregnancy test.

I: So it was not, were you well treated, or..?

Cheryl: They are really nice there.

Alice: Yeah, they are nice.

Consequences Associated with Different Selection of Strategies

The consequences associated with strategy selection are varied and have been described in relation to each kind of risk managing strategy. In Table 6, a summary overview of the contrasting outcomes associated with strategy selection is presented.

Table 6

Associated consequences in terms of type of risk

Strategies	Peer Risk	Job Risk	Potential personal health risk	Potential peer health risks	Intervention or treatment for condition*
Type of strategy and health condition					
Avoiding Strategies					
Minor Condition	—	—	—	—	—
Stigmatizing Condition	—	—	YES	YES	—
Minimizing Strategies					
Minor Condition	—	—	—	—	YES
Stigmatizing Condition	—	—	YES	YES	—
Embracing Strategies					
Minor Condition	YES	—	—	—	YES
Stigmatizing Condition	YES	YES	—	—	YES
Unquestionable Condition	—	—	—	—	YES

* Refers to formal treatment and intervention with local health service providers.

In summary, the dominant perspective identified in the ASP/SP approach to addressing health conditions was the control of perceived social risk. The more narrow focus, or designation in dimensional analysis parlance, was stigma avoidance. Table 7 provides a summary overview of the complete dimensional analysis. See also Appendix G for detailed presentation of each health condition

Table 7

Perspective: Controlling Perceived Social Risks

Attributes	Context	Condition	Action	Consequences
Nature of the health condition Stigmatizing Minor Unquestionable non-stigmatizing	Adolescents and young adults Inexperienced in independent living Separated from family and friends Living in a small community Transient residents Have low paying jobs	Fear of confidentiality and anonymity transgressions Cues from peers regarding the health condition Social Barriers Cues from peers regarding the local formal health services SP attitude towards local social/health care providers Employers' attitude towards taking time from work Logistical barriers Time constraints Financial constraints Visibility of local formal health services Poor understanding of how to access local formal services	Strategies selected Avoiding Minimizing Embracing	+/- social risk w/ peers +/- social risk re job +/- intervention for condition +/- individual health risks +/- peer health risks

In the following chapter, the current findings will be discussed in relation to other research on adolescent health, adolescents and risk, health decision making, and stigma avoidance. The lack of literature discussing the health behavior or decision making of young adults in tourist or resort towns guided the selection of this literature as context for discussion of the study findings.

5. Discussion

In this chapter, several elements of the SP study, its findings, limitations, methodology, and relationship of the findings to other bodies of related literature are presented. The focus will be on the group of young or adolescent informants who came to Jasper for a summer season of work. This was the original group identified for study.

In the course of data analysis, it became apparent that two groups within the SP existed. These two groups have been differentiated by the terms SP and ASP. SP was the original term given to the group for study, but the term ASP better characterizes this group of youth who remain for one summer season. The SP, as differentiated from the ASP, then are a group of transient young adults who come to work in Jasper's hotel and tourism industry but who remain in Jasper longer than one tourist season.

The purpose of this study was to understand perceptions of the group now designated as the ASP about their personal health issues and access to health services and relevant resources. Because the differentiation between ASP and SP occurred late in the recruitment and data analysis, information was gathered from both ASP and SP members regarding strategies to deal with health conditions. A qualitative, inductive approach was taken in this inquiry because neither the ASP nor the SP had been studied previously. Findings indicated that managing perceived social risks associated with health conditions such as issues related to alcohol, pregnancy and sexually transmitted diseases was the prominent dimension of the ASP's endeavor to deal with personal health issues. Specifically, strategies to deal with personal health conditions, implemented by the ASP and SP, included Avoiding Perceived Social Risks, Minimizing Perceived Social Risks, and Embracing Perceived Social Risks.

Originally, a strong focus on SP's perceptions of determinants of health pertinent to their experience was included in the study design. Due to the apparent inability of ASP/SP respondents to articulate perceptions of these factors, this focus was not retained in a dominant place in the study. Findings in the study do, however, indicate the importance of several determinants of health in the lives of ASP/SP members which have been discussed. These factors include housing, income and social support.

In this study, social risks were defined previously as risks to peer relationships and to employment of ASP and SP members. The predominance of data about use of strategies to manage social risk came from focus group members who were younger. Secondly, ASP members are at a life stage when identification with a peer group is a primary challenge. For the ASP members who are in their late teens and early twenties, achievement of this milestone may have been an underlying force that created the need to preserve status within a peer group, potentially at the expense of their health.

The ASP informants from the focus groups demonstrated characteristics more like adolescents than the SP members interviewed individually. They differed from other SP members in the content of their responses and stories and the recruitment process that was effective. Their stories emphasized a summer in Jasper as a summer break in which socializing, partying, and recreation were highly valued. Many SP respondents relocated to Jasper for longer time periods and employment was more highly valued than partying. The ASP were usually recruited through invitations to participate in discussions occurring the same day and, for respondents, required little advance planning.

ASP and SP Strategy Selection

Data analysis indicates a propensity of ASP and SP respondents to select different strategies to attend to health conditions. In the case of negating strategies, while both ASP and SP informants described using both ignoring the condition and avoiding local formal health services, motivation for the selection of these strategies differed. Financial constraints were identified as a barrier for SP informants that influenced their decision to either ignore the condition or to avoid local formal health services. Many of the SP were from out of province, were not yet covered by the Alberta Health Insurance Plan (AHIP), and therefore were financially responsible for visits to local formal health services. ASP informants discussed fear of compromised confidentiality as a powerful influence in avoiding local formal health services.

Developmental Issues and Selection of Social Risk Management Strategies

The adolescent developmental tasks of identifying with a peer group and individuation from the family unit seem to be fundamental to ASP motivation underpinning the strategy selection for managing social risk. In addition, most health conditions for which ASP members described implementing Avoiding Strategies, that is ignoring the problem or avoiding the local formal health services, fall within the category of social morbidities. Social morbidities are threats to health which are the "consequence[s] of social, environmental or behavioral factors" as opposed to biomedical factors (DiClemente, Hansen & Ponton, 1996, p. 2). For the ASP, the most prominent social morbidity is related to sexual health conditions. These health conditions differ from both the minor health conditions and the unquestionable, non-stigmatizing health conditions. The prime difference lies in the volitional nature of the behaviors that lead to the STD, pregnancy, or fear of pregnancy (stigmatizing conditions). Minor and unquestionable, non-stigmatizing health conditions were, for the most part, physiologic or traumatic in etiology. The difference between minor and unquestionable health conditions is one of degree rather than of kind. The difference between stigmatizing conditions and the minor or unquestionable, non-stigmatizing conditions is one of kind rather than of degree.

To set context for a discussion of the SP/ASP demarcation, an overview of adolescent development is presented. The developmental discussion includes general, psychosocial, and cognitive adolescent development as well as age/stage appropriate developmental tasks.

Parameters of Adolescent Development

Health and medical literature on adolescence describes this developmental stage as the period between 10 and 21 years of age (Bennet, 1988; College of Family Physicians of Canada, 1993; Kriepe, 1985; Lohner, 1987). Some authors use 19 years of age as the upper limit of adolescence (Sells & Blum, 1996a) and some ambiguously refer to the parameters of adolescence as a period beginning with the onset of puberty and ending some 10 to 15 years later with the "attainment of emotional and economic independence" (Nicholi, 1988, p. 637). Regardless of the parameters used to designate the period, adolescence is the developmental bridge between childhood and adulthood.

A disparity in identifying stages within adolescent development exists in the literature, as well. Some authors identify three stages of adolescent development: Early adolescence, approximately 10 to 13 years; Middle adolescence, approximately 14 to 17 years; and Late adolescence, approximately 18-21 years (Bennet, 1988; Kreipe, 1985; Lohner, 1987). Others refer to a two stage schema of early and late adolescence (Nicholi, 1996). Whether a two or three stage schema is held, the common notion of adolescence occurring in stages denotes differing challenges and behavioral tasks to be achieved within this transitional developmental period. In the present study, all participants were a minimum of 18 years of age. This indicates that only the later phases of adolescent development are pertinent to the discussion of the SP. Where mentioned, earlier adolescent development is cited to demonstrate continuity in the general adolescent developmental trajectory and provide context.

Social risk control strategies: Cognitive and psychosocial development underpinnings

Cognitive and psychosocial development of late adolescence underpins the ability and need for the ASP to formulate a variety of strategies to manage their personal health and perceived social risks. Without maturation of these areas to a late adolescent level, the creation of strategies, especially strategies that encompass problem solving and extrapolation of social consequences, would not be possible. These two areas of development are briefly presented.

Cognitive theory depicted by Piaget (1979) describes adolescence as a time of passing from concrete operational thought at the onset of adolescence to formal operational thought in late adolescence. This cognitive maturation facilitates mastery of the increasingly abstract and complex challenges facing adolescents on the threshold of young adulthood, autonomy, and the many accompanying responsibilities.

Erikson (1963) depicted eight emotional stages of human development, each with accompanying milestones. For adolescents, resolving the tension of the identity vs. role confusion dyad is the primary emotional milestone. With successful resolution of this milestone, the adolescent's self-identity or self-concept is established.

An alternate view regarding adolescent development is professed by some authors (Gilligan, 1986, 1988; Stern, 1990). This school of thought is critical of more traditional theories of adolescent development that fail to consider more prominently the experience of young women in the developmental process and emphasizes relationships as a fundamental phenomena for study during this period. This view, which emphasizes moral development, was not fully integrated into the present discussion for two reasons. Gilligan's work has drawn extensively from research conducted primarily with young women. The present study was concerned with a mixed sample of young men and women. Further, the present study's focus on managing perceived social risk and to some extent strategy selection is seen as more circumscribed than generalized discussions on moral reasoning.

The strategy selection of the ASP was influenced greatly by the fear of losing friends. This was noted most clearly in the strategies suggested by ASP respondents in managing stigmatizing conditions: Risk Avoiding Strategies. In selecting Risk Avoiding Strategies, the ASP placed a higher value on the preservation of peer relationships than on protection of their individual physical health. The reported fear of losing confidentiality regarding a potential visit to the local formal health service, especially for sexual health conditions, is pivotal in this group's strategy selection. Few ASP members report selecting the Risk Minimizing strategies of self care or accessing informal health resources. It is speculated that the paucity of selecting these strategies is due to the ASP's lack of experience with managing the mundane responsibilities of independent living, including basic self care skills. Further, these ASP members spend a relatively brief period of time in Jasper and then they return to home or school where structures to guide ASP members are in place. The ASP, most likely, does not play a lead role in these familiar structures. The time in Jasper is also so brief that it is not likely that this basically healthy population would encounter many opportunities to learn self care skills. Other than the reported cold[1] that most SP and ASP members describe as something that accompanies moving to Jasper, most ASP probably do not have the opportunity to exercise self care skills. Obvious exceptions to this are the ASP members in the current study who describe the challenges of managing chronic illnesses such as migraines and seizure disorder. The implementation of Risk Embracing Strategies by ASP members is, in some ways, a negative case in strategy selection by this group. In these scenarios, the drive to protect peer relationships demonstrated in risk negating strategies is superseded by the perceived gravity of unquestionable, non-stigmatizing health conditions.

Opportunities to Stretch. The experience of going to Jasper for a summer of work structurally provides the ASP with the opportunities to work through the developmental tasks of individuation from family and seeking acceptance with peer groups. Friends comprise the social network and informal support system for the ASP. The strong bonds among ASP members characterize the normal task of adolescence of identification with peers while individuating from the family unit. For the ASP in Jasper, this developmental task is more concretely played out due to the (often) great physical separation from family and previous social networks. Fledgling experiences with social and financial autonomy and sexual identity formation are shared with the new social community of other ASP members, who are both fellow adventurers sharing the experiences and judges proclaiming the criteria for acceptance.

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[1] It is speculated that crowding in housing situations predisposes the SP and ASP to communicable diseases such as upper respiratory diseases. With permanent and temporary staff housing at a premium in Jasper, most transient workers reside in shared living accommodations.

Adolescent Developmental Tasks

Lohner (1987), encompassing traditional cognitive and behavioral constructs, summarizes adolescent developmental tasks in a manner that captures milestones and provides a glimpse of other adolescent challenges. These tasks include:

> win acceptance of peers and society; achieve independence from the family; develop the capacity to love a person of the opposite sex[2]; achieve an effective ego, a sense of self, an identity (including body image, self-image (values, virtues, faults), sexual identity and vocational identity; achieve an effective super-ego, a conscience, a value system and a sense of right and wrong. (p. 18)

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[2] This is a traditional and conservative expression of the relationship building with a significant other. In fact, young adults may enter into relationships with same sex significant others.

Late Adolescence. SP and ASP members commented on the importance of friends in a Jasper lifestyle. For many, these alliances encourage and support the testing of such late adolescent tasks. Concomitantly, the absence of immediate family influence for the ASP heightens the reliance on peers as a resource, sounding board, permission giver, and source of emotional support. Late adolescence is the threshold from whence adult responsibilities and privileges are viewed--and sometimes tried on for size. As previously mentioned, an exact demarcation of late adolescence as a period is contested in the literature. For this reason, a functional approach to identifying this period is offered. This functional view is suitable for exploring the issues and developmental tasks faced by the ASP.

> Late adolescence begins for a large majority of individuals upon graduation from high school. Whether they obtain a job or go to college, they enter a phase dedicated primarily to the task of defining who they are and establishing some notion of what they want to become. (Nicholi, 1996, p. 645)

During this time of identity consolidation, late adolescents prepare to separate from their families. Combined with the physical and sexual maturity that characterizes this stage, late adolescents are poised to engage in mature interpersonal relationships that include sexual intimacy. The importance of peer relationships comes to the fore as individuation from family and identification with a non family, often peer, group emerges.

Adolescents and Risks

In the current study, risk has been discussed mainly in the context of social risk associated with ASP peer relationships and to a lesser degree risk regarding the relationships of the ASP with employers. The concept of social risk emerged from the findings during analysis of the strategy selection to address stigmatizing conditions. The paradox of ASP members taking active steps to protect peer relationships by avoiding circumstances where stigma related to health conditions could be exposed, at the potential price of physical well being, alluded to this concept of social risk.

The expanse of literature on adolescents and risk and risk-taking behaviors demonstrates the integral nature of adolescence and risk. A more general view of adolescents and risk is presented to increase understanding and use of the current findings. Beginning this discussion, Jessor's (1991) differentiation between risk behavior and risk-taking behavior in adolescents is useful. In addition to providing a psychosocial perspective for the concept of risk, Jessor provides a definition of risk (albeit, epidemiologically influenced) and a conceptual framework to "facilitate both an understanding of and action in the arena of adolescent risk" (p. 597).

Jessor (1991) places risk-taking behavior as a subset of risk behaviors among adolescents. A defining characteristic in the concept of risk-taking in this case is an awareness of "risk or danger involved and a deliberate seeking for the thrill that issues from the uncertainty of beating the odds" (p. 599). To emphasize the difference between risk-taking behavior and risk behavior, Jessor emphasizes the efforts employed by health educators to bring adolescents into awareness of the many risks that accompany their behaviors. Further, he argues for a more general conceptualization of risk behaviors in this way: "It seems best... to employ the term risk behavior rather than risk-taking behavior and to apply it to any behavior that can compromise adolescent development --whether or not the adolescent is motivated, or even aware of the risk involved" (p. 599).

Both risk behaviors and risk-taking behaviors are an integral part of the ASP lifestyle. The strategy selection to manage social risk as defined in the present study is an attempt to manage risk to peer relationships or jobs as perceived by the ASP. Actually, the nature of some of the strategies selected, especially those chosen for the stigmatizing conditions, are risk behaviors of a different scale, engendering risks to the personal health of the ASP and potentially their peers. In a discussion in the second focus group, the 24-year-old demonstrated awareness of the risk associated with avoidance of treatment for STDs, while other ASP members voiced concern for the lack of confidentiality that might accompany seeking treatment. Selection of this strategy is seen as a risk behavior selected amidst a lifestyle hallmarked by a cluster of risk taking behaviors.

Adolescents and Risk-taking

All respondents in this study discussed the lifestyle of the ASP and some SP and seasonal workers as characterized by an atmosphere of partying. Partying included significant alcohol consumption, social interaction including sexual activity, and sometimes recreational drug use. Drug usage was not explored in detail in this study. As noted by two of the NSP informants, significant alcohol consumption, even to the point of alcohol poisoning, has been noted in this population.

Stories of sexual activity are also prominent in these discussions of the party lifestyle common to ASP members. In the presence of significant alcohol consumption, the question of the disinhibitory effect of alcohol and the consequences for sexually active ASP members come to the fore. Simply put, when intoxicated, a person, particularly a young adult, may engage in activities beyond that in which he or she may choose to engage when sober. A decision to be sexually active while intoxicated is an example here. Additionally, the disinhibitory effects of significant alcohol consumption may interfere with the exercise of protective limits or prohibitions that one would exercise if sober. In this case, abandonment of safe sex practices while intoxicated is a case in point. Some authors refer to this compounding of risk factors as risk behavior syndrome (Jessor, 1991).

Risk-taking and adolescence has been widely studied. The following discussion on this topic provides a backdrop. The selection by ASP members of strategies to manage social risk occurs in the context of reported lifestyles that demonstrates risk behavior syndrome (Jessor & Jessor, 1977), or a clustering of interrelated distinct risk behaviors (Osgood, Johnston, O'Malley, & Buchanan, 1988). Of note is that both these discussions conceptualize the behaviors as deviant behavior. The present study did not use deviance as a frame of reference.

Risk-taking during adolescence is a common phenomenon that has been situated in several theoretical frameworks. Irwin and Millstein (1992), in discussing the commonality of risk-taking behavior and current morbidity and mortality trends for adolescents, provide the following view of risk taking behavior. These authors highlight the volitional nature of risk taking among adolescents:

> Young people with little or no experience engage in potentially destructive behaviors with anticipation of benefit and without understanding the immediate or long term consequences of their actions. Even though some risk taking is necessary in the normal developmental process, often the short and long term results of risk taking are disastrous.... Inherent in the risk taking terminology is an implication that the behavior has a volitional quality in which the outcome remains uncertain. (p. 76)

Baumrind (1987), coining the term "eustress," described risk taking during adolescence as a common and purposeful occurrence and one that contributes to the development of self confidence, competence, and initiative. Irwin and Millstein (1992) similarly describe adolescent risk taking behavior as a phenomenon that addresses developmental needs of increasing autonomy. Irwin (1987) differentiates constructive from negative risk-taking behavior in adolescence, stressing the exploratory nature of the former construct. A few of the many other frameworks including adolescent risk taking behavior are problem behavior theory (Jessor, 1977), the clustering of risk taking behaviors as deviance (i. e. alcohol or substance use, dangerous driving, and criminal activity) (Osgood, et al. 1988), the covariance of risk-taking behaviors as problem behaviors (i. e. concurrent alcohol use, cigarette smoking, premature sexual activity) (Irwin & Millstein, 1992; Jessor, 1991; Jessor & Jessor; 1977), biological links with risk taking behaviors (Udry, 1990), adolescent risk taking behavior related to their perceived invulnerability (Elkind, 1967) and risk taking as preventable health risks (Ginzberg, 1991).

ASP/The strategies.

The ASP describe behaviors and lifestyle that is fraught with clusters of risks. Generalized partying that included extensive alcohol intake at local bars or at private parties was the primary risk behavior described. Some illicit drug use was also described, but the high cost of these drugs placed financial constraints on use. Since few ASP members owned or had access to cars, driving while intoxicated was of lesser concern with this group. Some NSP informants described physical injuries and legal infractions experienced by SP/ASP members while intoxicated. (At the time of the NSP interviews, no differentiation between ASP and SP members had been made.)

The most concerning compound risk for the ASP in light of heavy alcohol intake is potential unprotected sexual activity. In light of the concerns regarding STDs and potential pregnancy that were discussed with the ASP, attention to this compound risk is warranted. Related to this direct compound risk is the indirect risk of avoiding treatment at local formal health services.

High Stakes Risks: Stigmatizing Health Conditions

This returns to the nature of the condition that triggers strategy selection. Of particular concern is health conditions that are stigmatizing. The decision to ignore the condition or to avoid seeking local formal health service intervention places the ASP individual at personal health risk. One of the driving elements underlying efforts to manage this perceived social risk is the avoidance of stigma which may result in the loss of peer relations or a job.

Some health conditions experienced by the SP/ASP were associated with intensely negative perceptions. These conditions were called stigmatizing conditions. Projected consequences of stigmatizing conditions included loss of standing in peer relationships or employer/employee relations. The health conditions which the ASP classified as stigmatizing primarily included sexual health conditions including STDs, pregnancy and fear of pregnancy. Initially in the present analysis, stigma avoidance seemed to be a driving force in the development of strategy selection to manage social risks.

After extensive review of the literature on adolescent psychosocial development (Piaget, 1979; Erikson, 1963) and the developmental tasks facing this age group (Lohner, 1987), this role of stigma in ASP strategy selection was modified. It is still held that stigma avoidance is an important mechanism to protect a vital, local support system while dealing with separation from family, friends, and familiar, stable, predictable surroundings, but the import of securing and maintaining peer support among adolescents cannot be overlooked in this question.

The classic exploration of stigma was provided by Goffman (1986) in 1963. In this work, three types of stigma are identified: a) "abominations of the body" (p. 4) or physical deformities, b)"blemishes of individual character" (p. 4) such as mental disorders, alcoholism, unemployment, etc., and c) "tribal stigma of race, nation and religion" (p. 4). Of these three types of stigma, the second type, blemishes of individual character, is the only category of non-visible stigmas. While this type of stigma does not characterize the invisible threat of STDs or AIDS, it is the only type from Goffman's typology that is not tied to physical characteristics or limitations.

Adolescents and Stigma

Psychology, nursing, and allied health professional literature contain discussions about adolescents and stigma in many contexts. These include: substance use (Anderson, 1994), maternal employment (Montemayor & Clayton, 1983), obesity (Sobal, 1984), wearing a scoliosis brace (Emans, 1984), mental retardation (Rowitz, 1988), learning disabilities (Szivos, 1991), being gifted (Cross, Coleman, & Stewart, 1993), parents with AIDS (Aronson, 1995), formation of a gay or lesbian identity (Kottman, Lingg & Tisdell, 1995), and using mental health services (Lincoln & McGorry, 1995).

Stigma and the ASP is an issue of negative labeling and exclusion not an exercise in control and power. The motivation behind stigmatization associated with certain health conditions is not fueled by power brokering to gain position or enforcing marginalization on another group as is the case in some discussions about stigma (Gilmore & Somerville, 1994). The ASP perceive themselves, potentially, as on the receiving end of a stigmatizing label. The fear of stigma in this case is associated with loss of interpersonal relationships within the SP/ASP peer community. Stigmatization occurs at the cost of social support.

The nature of adolescence, especially late adolescence, is one of uncertainty and speculation. While searching for an identity that both fits and is less tied to the sense of self as a family member, adolescents hope for, wonder about, critique, test, evaluate, and speculate about behaviors and choices that will lead to their newly forming adult role. For the SP and ASP alike, Jasper provides an experimental setting in which this trial is conducted.

Many SP and ASP informants stated that friendships were very important to them. Peer support from other SP members compensates for the lack of support that might normally be provided by family members or long time friends who are back home. SP peers also represent a transitional group with whom new alliances and commitments facilitate individuation from family. It is not claimed that this process of individuation takes place in one summer season nor that the individuation process would not occur had the individuals not come to Jasper to work for the summer. Rather, it is postulated that a unique pilot opportunity is presented for those ASP who find their way to Jasper. For many, the end of the summer means a return to their regular life. While this group has the opportunity to try out new skills and engender risks during this summer period, they remain vulnerable to the potential physical and psychosocial outcomes of a lifestyle characterized by clustered risk behaviors/risk behavior syndrome.

Beyond Goffman

Because Goffman's work (1963) was published in a pre AIDS/HIV era, the three categories of stigma identified by Goffman do not well capture the essence of stigma related to blood borne diseases such as Hepatitis B and STDs including AIDS. Gilmore and Somerville (1994) provide a compelling, contemporary view of stigma and STDs, including AIDS. In their discussion of AIDS as a STD, these authors delineate three characteristics of STDs that "predispose to stigmatization" (p. 1349). First, the majority of STDs require intimate contact for transmission. "This means that the behavior responsible for the transmission of these diseases is private or intimate. Being infected with a STD can bring about public disclosure of such private or intimate behavior" (p. 1349). For many persons, especially adolescents, the threat of such a potential disclosure is grave. The second of Gilmore and Somerville's characteristics centers around the invisibility of STDs. Since carriers of an STD are not visibly identifiable, to avoid subjecting oneself to an STD, three options are available: complete avoidance of sexual encounters, disclosure of STD status, or "unilaterally taking precautions " (p. 1349). If, however, a person with a STD was stigmatized or identified as having an undesirable sexual health condition, then other group members could implement another protective mechanism by avoiding intimate contact with that affected individual. While discussing STDs in the second focus group, the fear of losing friends secondary to being stigmatized with having a STD was mentioned. Additionally, the small size of the town and the perceived impossibility of keeping positive status regarding a STD confidential was an integral part of this scenario.

There is a dangerous weakness in relying on this protective mechanism. By believing that safety measures are being implemented through avoiding intimate contact with the known, stigmatized person(s), false security as to the non-infectious nature of other persons who are not similarly stigmatized may exist. That is, a lack of commonly understood stigma does not guarantee that another stigma-free person is disease free.

The third characteristic in Gilmore and Somerville's (1994) discussion is related to the social construction of sexual activity as a behavior that, in a classic stigmatizing manner, challenges "public and private religious, cultural and political values" (p. 1349). In this case, the process of stigmatizing persons who defy certain values is a mechanism for neutralizing these persons and their potential influence in 'Scarlet Letter' fashion.

STDs, AIDS, and Stigma

In current health and social science literature, discussions of stigma associated with AIDS and STDs abound (Alonzo & Reynolds (1995); Crawford

(1994); Crawford (1996); Gilmore & Somerville (1994);Kadushin (1996); O'Keefe (1994); Pryor & Reeder (1993); and Weiner, 1996). Little discussion was found in allied health and social science literature on the association of stigma and AIDS prior to 1986. Most of the literature was published in the 1990s.

The expansion of this line of thought in scholarly literature may be a reflection of the evolution of thought concerning the AIDS crisis and its impact on perceptions of sexual health/illness. Objectification of the phenomenon of AIDS, HIV positive status, and other STDs occurs in these conceptual explorations. These scholarly discussions indirectly impact on the SP or the ASP. As markers in intellectual discourse regarding sexual health/illness, these discussions on stigma and their growth reflect the permeation of a negative connotation that is associated with sexual health conditions. If this negative connotation of sexual health were not pervasive in contemporary life, such extensive scholarly analysis and attention would not be warranted to document or explore the phenomenon. Against this social theme, ASP members test out autonomy, grapple with the late adolescent tasks of attaining sexual maturity, leaving the family and cleaving to peer groups, and measure inherited value systems.

Adolescents, Action, and Sexual Conditions

Literature indicates that the hesitancy of adolescents to acknowledge or take action in the case of STDs is not associated exclusively with the perceptions of peers regarding the situation. Friedman (1989) reported reluctance on the part of adolescents to seek treatment for STDs. "On socially sensitive matters, particularly to do with the consequences of sexual behavior...[adolescents] are less likely to come forward for care and more likely to come late when they do" (p. 310). One of the obstacles to adolescents seeking professional intervention for STDs identified by Friedman was a specific anticipated response by health care providers. This author speculated that adolescents anticipate the reactions by health care professionals in this instance to be characterized by lack of sympathy or even "anger and hostility" (p. 312). Friedman also postulates that "inexperienced or ashamed" (p. 312) adolescent women who seek abortions for unwanted pregnancies are similarly likely to seek intervention later in their pregnancy. Thus immediate and future health status is placed in jeopardy.

Taxonomy and Catastrophe : The ASP Perception of AIDS

The ASP categorized AIDS with catastrophic illness rather than sexual health. This is to be noted clearly. The informal taxonomy created by this group placed AIDS in a category with a terminal illness that seems to have little bearing on their daily life. Other sexual health conditions such as STDs, pregnancy, and the fear of pregnancy were discussed by ASP informants in the context of absolute possibility.

The perceived invincibility that accompanies their developmental stage may play a role here (Irwin & Millstein, 1992). The disbelief that one might contract AIDS may have contributed to the relegation of AIDS to the catastrophic disease category rather than the sexual health condition category.

It would seem that the sexual health issues most relevant to the ASP are non-AIDS STDs and pregnancy issues. The greater backdrop of thought as reflected in academic literature indicates that, currently, stigma is associated less powerfully with these conditions than with AIDS. This difference in perspective may be an issue of scale and maturation. The potential implications of this difference in perspective is a source of concern for the ASP health behavior.

Perceived Risk Management Strategy Selection

The etiology of health problems commonly facing adolescents provides context for understanding the ASP strategy selection in relation to conditions identified as stigmatizing in this study. For the most part, the physical maturation that marks adolescence is characterized by good individual health. Unlike younger children who are more vulnerable to diseases (Friedman, 1989), the health problems of adolescents are most often related to different etiologies.

The present study did not address mortality issues with the SP; however, discussions of morbidity and mortality issues frequently are juxtaposed in health literature. Sells and Blum (1996a) describe a shift over the past three decades in the trends of causes of death in adolescents "from natural to violent etiologies" (p. 8). Causes of adolescents' death cited in this shift include motor vehicle fatalities, homicide and violent crime, and suicide. Additionally, these authors note a rise in the rates of both victimization of adolescents in violent crime and also juvenile violent arrest rates. The major morbidities for adolescents include alcohol and substance abuse; tobacco use; reproductive health issues, including sexual intercourse, contraceptive use, sexually transmitted diseases, teen pregnancies, and abortions; HIV and AIDS; sexual and physical abuse; runaway and homelessness incidence; mental health disorders; and eating disorders. These morbidities, which are related to life style practices more than biomedical issues, are called social morbidities (DiClmente, Hansen, & Ponton, 1996; Rickert, Jay, & Gottlieb, 1990). Many of the issues in this class of social morbidities relate directly or indirectly to adolescents' challenges in attaining previously mentioned developmental tasks and to the risk-taking behaviors that occur during adolescence. An additional factor contributing to the incidence of social morbidities is the perceived invulnerability experienced by many adolescents (Irwin & Millstein, 1992).

Models of Health Behavior

Adolescents and decisions about health.

Many models for exploring and describing health behavior motivation have been commonly cited. Among these are the Health Belief Model (Basen-Engquist, 1992; Becker, 1974; Rosenstock, 1990); Social Learning Theory (Bandura, 1977), Theory of Reasoned Action (Fishbein & Ajzen, 1975), Locus of Control (Rotter, 1966), and development of social identity through self-categorization theory (Hopkins, 1994). Additionally, within the field of adolescent health, the process of health-seeking behaviors among adolescents (Eisen, Zellman & McAlister, 1985; Newell-Withrow, 1986), models to explain and predict adolescent health behavior (Tappe, 1992; Langer & Warheit, 1992), and utilization of health care by adolescents (Hodgson, Feldman, Corber, & Quinn, 1986) have been explored, but further work in these areas is warranted.

Of these models and theories from the adolescent literature, Tappe's 1992 Model of Personal Investment (MPI) and Langer and Warheit's 1992 Pre-Adult Health Decision-Making Model (PAHDM) are of particular interest regarding the findings of the present study and future research implications. Recent work on the human ecology (Green, Richard, & Potvin, 1996) or social ecology theory (Stokols, 1996) and health promotion may also be useful in further explorations of this topic. Presently, however, social ecology's applicability to an adolescent population, adolescent health behavior, or decision making activities is preliminary and requires exploration.

Three frameworks proposed for future exploration are similar to the present study in the common structure that guides the organization of the conceptual or common framework for the works: antecedents, phenomena, and consequences. They differ from the current study in a focus on predicting/controlling phenomena as distinct from contributing to an understanding of the phenomena

The Model for Personal Investment. Tappe (1992) reviewed many theories and models, including many mentioned above, pertaining to health behavior, decision making, and adolescent development. Useful constructs within each theory or model were then synthesized into one framework. The result of this metanalysis-like process is the MPI. Tappe (1992) summarizes the MPI in this way:

> The MPI is...a motivational framework in which constructs from existing theories and models of motivation and health behavior are integrated into a comprehensive approach to explain and predict adolescent health-related behavior. In this model, the subjective meaning of a behavior is proposed as the critical determinant of an individual's personal investment or engagement in the behavior. (p. 277)

The MPI is brought to the fore for three reasons: the intent of the model focuses on adolescent health behavior, the format of the model is similar to the format achieved in the present study, and, the items within each category of the framework bear a resemblance to the items in the framework emerging from the current analysis.

The framework used by Tappe (1992) in describing the mechanism to predict adolescent health behavior is similar in structure and content to the framework used in the present study. Tappe's model depicts the interrelationship among antecedent variables, person-environment variables, and adolescent behavior.

The present study explored management of social risk and the strategies selected by the ASP to attend to health conditions. This is taken to be a narrow construct which could be located within Tappe's (1992)broad framework of adolescent health behavior. Tappe's frame work could be used directly or as guiding pertinent review for a future study of the ASP's behavior regarding intervention seeking for sexual health conditions and/or more generally to explore the ASP's sexual health behavior and implications for health promotion and education programs for this group.

The Pre-Adult Health Decision-Making Model. The PAHDM model is designed to depict adolescent behavior regarding health issues. The gross structure of context-action-consequences is similar to the previously described analytic structures.

A component of particular interest in the PAHDM is the directedness/orientation component. This component, based on Riesman's (1950) work, refers to one of three potential orientations describing influence on adolescent decision making: tradition-directed, inner-directed, and other-directed. Langer and Warheit (1992), noting Riesman's suggestion that individuals may assume different types of directedness/orientation during the course of their lifetime describe each of these three types for comparison. The tradition-directed orientation, characterized by conformity, is seen to run "parallel to the parent-directed adolescent whose perceptions have been focused on the referents established by the socialization of parents" (p. 932). The inner-directed type is compared to the "self-directed adolescent who relies on personal norms and values instead of those advanced by others when making a decision" (p. 932). The other-directed type, a characteristic that may have been demonstrated in this study's perceived social risk management, is also called peer-directed. This type is compared to an "adolescent who no longer wants to rely on parents and/or seeks direction and approval from peers" (p. 932).

Langer and Warheit (1992), criticizing Riesman's (1950) typology as being too rigid and categorical, revise this view of directedness from discrete categories to variations on a continuum. Directedness then becomes the central component of the PAHDM. These authors cite the focus of the PAHDM as exploring "how referent groups associated with decision-making direct and reinforce the attitudes, beliefs and behaviors related to risk" (p. 933).

Jessor's (1991) conceptual framework is also relevant to the findings of this study. It includes a well-constructed overview of risk and risk-taking behaviors in adolescence, the acknowledged interrelation among conceptual domains that act as determinants or antecedents leading to risk laden behaviors, and the breadth of potential risk outcomes. Similar to other frameworks discussed, this framework is constructed with a set of interrelated factors concerning the individual and his/her environment leading to a behavior and ultimately connected to a series of outcomes.

Socioeconomic Status of the SP

Although in this study information was not collected to describe the socioeconomic status (SES) of the SP or their parents, this data would be useful. Fasick (1984) suggested that parental social class has a direct negative impact on adolescents' behavioral autonomy but a curvilinear relationship with the importance of youth culture (peers) to adolescents. In very brief form, Fasick suggests that upper class adolescents experience little behavioral autonomy because their parents exert efforts to socialize this group for future leadership roles. This group attends private schools and engages in supervised activities. Additionally, leisure activities for this group are co-opted by parents as a process of their socialization, and so the role of peers or youth culture for this group is diminished.

Fasick (1984) suggested that adolescents from middle class families experience limited behavioral autonomy. This group usually attends post-secondary schools. They also experience some supervision of their activities, but an increased degree of freedom in leisure pursuits is allowed. This increased time spent in leisure pursuits allows for a more important role to be played by peer groups.

Finally, lower strata adolescents, who are more likely to leave school early, demonstrate the most behavioral autonomy of these groups and frequently have jobs. Fasick (1984) suggests that youth culture is "relatively unimportant" (p. 153) for this group. He also notes that the autonomy experienced by this group is "usually broader than leisure-oriented relationship with peers" (p. 153).

Concluding Thoughts

Several contributions arise from the present study. First, the study contributes information about Jasper's ASP and to some extent, the SP. Second, the newly evolving methodology of Dimensional Analysis has been utilized. Few reports of utilizing this method appear in qualitative research literature to date. Third, insight into the implications for accessing and recruiting a difficult-to-access population have been explored. Although no literature regarding this population was identified, the findings of the study have been examined in relation to developmental characteristics of adolescents and models of health behavior.

Finally, the unique contribution of this study is the identification and exploration of the strategy of prioritizing social risk over attending to potentially health compromising conditions as utilized by Jasper's ASP. Present work on this strategy suggests that adolescents and young adults in periods of transition and temporary employment place higher value on maintaining and protecting their informal social networks potentially at the cost of their personal health. This strategy may be applicable among other groups of adolescents and young adults and therefore deserves investigation in other such populations.

Limitations

One of the obvious limitations in this study was the inability to complete follow-up interviews with the ASP members. Had the ASP members been scheduled successfully for follow-up interviews, more clarity on topics specific to this subgroup of the SP may have been achieved. Inclusion of additional SP members from JPL would have increased the depth of information available about the unique characteristics of this site.

In addition, there was a lack of diversity in the sample and no information was obtained regarding diversity in SES, culture, or sexual orientation. All the ASP and SP informants were white, presumably middle class individuals. The experience of gay or lesbian ASP or SP members in Jasper is not known.

6. Conclusion

The present study provided the first look at the perceptions of Jasper's ASP/SP about their personal health issues and access to health services and relevant resources. A preliminary understanding of this group and the context influencing their decisions regarding health management and social risk control has been gained. Implications of the findings for nursing practice and areas for research in nursing have also been identified also.

Implications for Nursing Practice

With health and illness services moving increasingly to community settings, opportunities for nursing interventions addressing issues such as strategy selection to deal with personal health issues and related outcomes will become more important. Since adolescents' health decisions and strategies selected will have an impact on their health as adults, attention to this skill at a formative time is warranted.

Within the PHC context, several of the essential five PHC principles are relevant in this discussion including access to health care services; health promotion and self care; and intersectoral collaboration. Potential barriers of a social and logistical nature that impinge on the ASP's readiness to access health services have been identified. Because of these perceived barriers to accessing formal services, the importance of health promotion/illness prevention and self care programs for the ASP is underscored. The breadth of determinants that contribute to the health and well-being of the community of Jasper including the ASP, for example housing, requires input from with an intersectoral component.

AIDS was not a major focus in this study's design but, following data analysis, became an important component. This group's classification of AIDS as primarily a catastrophic disease, like a cancer rather than a STD, has implications for nurses working with adolescents. Clarification of the perceptions of adolescents as to the nature/taxonomic categorization of AIDS may influence the design of adolescent health education programs and outreach strategies. In the study, discussions about sexually transmitted diseases rarely included the mention of AIDS except as a different entity. If this predominantly healthy group perceives that AIDS is as distant from their reality as cancer, then nursing and other strategies aimed at AIDS prevention might benefit from shaping to include this information. For example, AIDS-related health education programs may be strengthened by the inclusion of reflective exercises that evaluate the perception of vulnerability to HIV contagion by this group.

In a similar fashion, the exploration of the impact of perceived stigma related to STDs and the help-seeking behavior of adolescents will inform nursing knowledge and practice. The present data analysis indicated that the ASP tended to avoid formal intervention for sexual health conditions. Of particular note for extrapolated work in this area is Friedman's (1989) implication that the cause for adolescents' lateness in seeking intervention for STDs is an anticipated negative reaction from health care providers. This anticipated negative reaction leads to a delay in intervention similar to the avoidance of local formal intervention described in the present study. Consequently, programs designed for adolescent health services would benefit from anticipating this as a potential barrier and mounting efforts, including training programs for personnel, to minimize such a negative reaction. This study was undertaken because it presented an opportunity to operationalize the principles of Primary Health Care (PHC). The present study is one of many research projects operationalizing PHC principles in a Canadian context. Similar to PHC studies conducted in developing countries, the everyday issues faced by individuals, groups, or communities in their attempts to seek, maintain, or improve their health are contextualized and explored. Understanding of the social context of the SP and their perceptions about health have implications for Primary Health Care services and health policy.

Some areas were identified that could lead to program and/or policy development. These areas include a self care project for SP/ASP members; the development of a SP Secretariat/Advocate; protecting, strengthening and expanding the existing network of local health promotion programs . During this study, each NSP informant (whose position of employment entrust him/her with responsibility for the well-being of the permanent and temporary residents of Jasper) was asked to identify a mechanism through which the SP could make their needs known to the persons with responsibility for the community. Almost all of the eight NSP informants identified different programs, mechanisms, or local organizations. This suggests a need to explore the development of a recognized body or mechanism to which SP members may bring concerns and questions i. e. social, employment, or health issues for the SP. This lack of a common vision or plan by which SP members might make their needs known or even have efficient access to give feedback to intersectoral leaders is an important area for future consideration. From the perspective of an informal network, consideration might be given to the dedication of a common, accessible (geographically and from the perspective of time) convenient space for ASP/SP members to use as a multi-use/gathering place. Provision of such a structure may support informal network growth and facilitate community integration for SP members deciding to remain in Jasper for an extended period of time. Another potential policy initiative that might be undertaken to support the health of the ASP/SP is the review and possible restructuring of provincial health insurance timelines. If these timelines for coverage were altered to allow the more rapid receipt of health care benefits in Alberta by ASP/SP members from other provinces a recognized barrier to accessing services of interventive and potentially preventive nature could be removed.

Issues for Future Research

Many issues discovered and emerging from the present study warrant future study. These issues may be addressed by nursing, interdisciplinary, and intersectoral research. Among these areas are the need for further study of the concept of developmental transitions, particularly in light of adolescent development; study of the strategy selection/health decision making patterns of adolescents, the implications of adolescent perceptions of AIDS as a catastrophic illness as opposed to a sexually transmitted disease; the exploration of the impact of perceived stigma related to STDs; and the help-seeking behavior of adolescents.

The present data analysis indicated that the ASP tended to avoid formal intervention for sexual health conditions. The congruence of these findings with Gilmore and Somerville's (1994) suggestions that STDs are particularly identified as stigmatizing and Friedman's (1989) suggestion that adolescents tend to seek intervention for STDs late in the course of a disease process underscores the importance of this area for future study.

There are several issues of gender and sexual orientation for Jasper's transient workers that could be explored. Among these are an exploration of female ASP constructs of moral reasoning and decision making based on Gilligan's (1986, 1988) alternative framework of relationship centered adolescent development. Further to this, an examination of gender-based SP social and physical risk behaviors and an exploration of the experience of gay and lesbian youth who come to Jasper as ASP or SP, members would be useful.

Baseline information on risks associated with the lifestyle of Jasper's transient workers could be established. A more detailed exploration of the association of risk clusters, particularly alcohol consumption and unprotected sexual activity among the ASP and SP would be of great importance for this population and the health care providers who care for them. Further work on alcohol and illicit drug consumption by the SP including the amount of alcohol consumption reported by the SP (partially corroborated by the number of empty bottles and multiple cases of empty beer cans observed in the residences of SP informants) warrants study. The described seasonal nature of drug use by the SP was fascinating and worthy of study. For example, hallucinogens such as LSD have more popularity in the winter season when life is described as more boring. Marijuana, cocaine, and mushrooms are more predominant in the summer season. All drug use was mediated by availability, but seasonal preference was clearly identified.

Specific areas for study suggested in relation to the SP subgroups within this topic. These include exploration of the pressures and coping strategies employed by SP members especially during shoulder season, which is a highly pressured and difficult time for this group of SP members, and exploration of the unusual experience and particular health needs of those ASP/SP members who are car and campsite dwellers.

Concluding Remarks

An important contribution of this study is identification of controlling perceived social risk as the dominant perspective of the SP members on personal health issues and accessing health care services and related resources. Findings of the study, which were summarized in the form of an analytic matrix, indicate the influential attributes of the perceived health issues, the life context experienced by adolescents, the specific conditions which influenced their strategy selection, and the consequences associated with their choice. Although it is not known whether these findings are typical of other similar groups of youths engaged in seasonal employment in a resort setting, the present study makes an initial contribution to understanding this vulnerable population.

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APPENDIX A

GUIDING QUESTIONS FOR ASP/SP INTERVIEWS

Guiding questions for SP Interviews

Introduction:

Can you tell me how you came to be working in Jasper for the summer?

What is it like to be a temporary resident who is here only for the summer?

How would you describe your contact with the other summer workers? (Probe: In what ways do you feel close to or distant from them?

What is it like to live in the town of Jasper? (Probes may include: In what ways do you feel you are a part of the community? are not a part?)

Taking care of yourself

What does it mean for you to be healthy? (not healthy?)

What kinds of things do you do to take care of yourself or keep healthy? (What things detract?)

What kinds of things do you usually do if you are sick or feel poorly? (Probes: friends or family consulted? medicines used? health professionals? emergency? medicentre? other)

Has there been a time this summer when you were sick? If so can you tell me about it and what happened? (Probes: what did you do? who did you talk to? did you visit any health service e.g. hospital? clinic? etc.? is there anything else you could have done?)

How would you describe taking care of yourself here as compared to being at home? (Probe: in keeping healthy or in dealing with sickness?)

What health services and resources are available in Jasper that you could use? Have you used any of these health services or resources? If so, can you tell me about it? (Probe: what was most helpful? unhelpful?)

Factors that affect health

From your point of view what are the things that affect your health? (Probes: things in your immediate environment? in the community?

I am going to show you a list of things that health professionals think are important for health. I would like you to comment on : a) whether you think each of these affects you or other summer workers? (use cards re determinants of health) b) in what ways?

Environment/Ecosystem

How would you describe the importance of the environment for health? (Probes: what changes, if any, are needed to improve the environment regarding its impact for personal health?

What kinds of things (if any) do you that help to protect the environment? that are detrimental?

In what ways if any is the quality of the environment important for health?

APPENDIX B

GUIDING QUESTIONS FOR NSP AND 'OTHER' INTERVIEWS

Guiding Questions for the non-SP subjects interviews

Introduction

How did you come to live in Jasper?

What is it like to live in a town that draws tourists and temporary residents seasonally?

Tell me about your contact with the temporary workers that come to fill seasonal positions.

Perceptions of the SP and health services and resource access

If a health or social service professional:

What are the health services and resources that the seasonal workers use?

How would you describe the way that the health services and resources in JNP match the needs of the seasonal workers? What are the ways in which the SP needs are not well matched?

What are the remarkable strengths in the JNP health services and resources network as regards the seasonal workers. Weaknesses?

What is your contact with the seasonal workers in regards to their health?

What are the services in JNP Townsite that seasonal workers use?

How do seasonal workers have their needs met if they are ill?

Factors that affect SP health

From your point of view, what are the things that affect the health of the summer workers?

How are these the same or different from the factors that affect the permanent residents in Jasper?

I am going to show you a list of things that are identified in health literature as important for health. I would like you to comment on how each of these effects seasonal workers.

Environment/Ecosystem

How would you describe the importance of the environment/ecosystem for seasonal health? (What changes if any are needed to improve the environment regarding its impact for personal health?

What kinds of things do you think the seasonal workers do to help protect the environment? that are detrimental?

APPENDIX C

RESEARCH CONSENT FORM FOR INTERVIEWS WITH SHADOW POPULATION (SP), NON-SHADOW POPULATION (NSP) AND OTHER RESPONDENTS

Consent Form

PROJECT TITLE: YOUNG SUMMER WORKERS' PERCEPTIONS OF HEALTH, ACCESS AND ENVIRONMENT

Researcher:	**Supervisor:**
Sheila M. Gallagher, RN, MS, Ph.D. Candidate	**Dr. Anne Neufeld**
Graduate Student	**Professor**
Faculty of Nursing	**Faculty of Nursing**
Home Phone: (403) 988-9476	**Office Phone: (403) 492-2699**
Jasper Research Office Number: (403) 852-6212	

PURPOSE: The purpose of this study is to understand three topics concerning the ways that summer workers in Jasper National Park (JNP) view : a)their ability to seek advice and treatment for their health and illness in the formal health care system and other places; b) the issues and stresses, including the environment, that affect the health of summer workers in JNP; and c) information about the relationship between the health of summer workers in JNP and the health of the JNP environment.

PROCEDURE: Two groups will be included. The first group will be made up of non-permanent JNP residents who have come to JNP to work this summer. The second group will be made up of persons who are permanent residents and have responsibility for the well-being of the summer workers and the JNP Town site in general. Summer workers will be invited to join a discussion group to talk about the topics concerning the health of summer workers. The discussion group will be tape recorded and typed. Follow-up interviews will take place with some members of this group. The reason for the follow-up interview is to double check parts of the typed copy that may not be clear to the researcher. In addition, some summer workers who did not come to the discussion group will also be interviewed one or two times. Each interview will last about an hour and will be held at a time chosen in a convenient location. The permanent residents will usually be interviewed once but will participate in a follow-up interview if the researcher needs to double check any information. All interviews will be tape recorded and typed.

PARTICIPATION: This study will provide no direct benefits to you, but the results of the study will help nurses and other professionals to make changes and plan programs to assist summer workers in the future.

You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time by telling the researcher. You do not have to answer any questions or discuss any subject in the interview if you do not want to. Taking part in this study or dropping out will not affect your care in the hospital or any community agency.

Your name will not appear on the typed interviews or discussion group or any future reports of the study or presentations. Only a number will be used. Only the researchers will have access to the list of code numbers and names. The list will be stored in a separate place. All tapes and typed copies will be kept in a locked cabinet separate from consent forms or code list and will be retained for at least seven years after completion of the study. Consent forms will be destroyed after five years. Information may be used for another study in the future if the researcher receives approval from the appropriate ethics committee.

Taking part in this study is voluntary. You may refuse to answer any question and you may withdraw from the study by telling the researcher. If you have questions or concerns about this study at any time, you can call the researcher at the number above.

A copy of this consent will be given to you.

(Signature of Participant) (Date)

(Signature of Researcher) (Date)

REQUEST FOR SUMMARY OF STUDY ON COMPLETION: (OPTIONAL)

If you wish to receive a summary of the study when it is finished, please complete the next section.

Name: ____

Address:

____

____

APPENDIX D

BIOGRAPHICAL INFORMATION FORM FOR ASP AND SP RESPONDENTS

Biographical Information Form for SP Respondents

Informant Code
Number:________________________ Date: ________________________

Age in Years: ____________________

Gender: ________________________

Highest Educational Level Achieved:

____
____

Number of jobs held this summer: ______

Hours per week in each job_____________
Job #1_____________
Job #2_____________
Job #3_____________

Employment Setting(s):

____
____

Length of time employed in this setting:____
____

First time working in Jasper? YES___________ NO___________

If NO, number of previous seasons worked in Jasper?

____

Position/job:____
____

Are you returning to this job?

____

Job Responsibilities:

____
____
____

Housing:

a) Type: e.g. share apartment? apt on first floor? basement?

____

____

b) Housing supplied by employer at no cost?

____
____

c) Housing supplied by employer for a fee?

____
____
____
____

d) Worker's responsibilities for housing

____
____
____

Meals:

a) Provided by employer at no cost

____
____
____

b) Provided by employer for a fee :

----

c) Worker's responsibilities for meals:

Wages: Hourly rate: --
Tips in addition? --
Average in tips per week --

APPENDIX E

BIOGRAPHICAL INFORMATION SHEET FOR NON-SP AND OTHER RESPONDENTS

Biographical Information Sheet for Non-SP and Other Respondents

Informant Code
Number:____________________ Date:________________________

Age: ____________________________________

Gender: ___________________________________

Highest Educational Level Achieved:

____

____

____

Employer:

____

____

Length of time employed in this
setting:____

Position/job:____

____

____

Job
Responsibilities:____

____

____

____

Interaction /Responsibility for SP
members____

____

____

____

APPENDIX F

RECRUITMENT FLYER

Are you working in Jasper this summer?

If you said 'YES!', a nurse who is doing a research study on summer workers in Jasper wants to talk to you.

ABOUT WHAT?

living in Jasper...health...taking care of yourself...your health and the environment...

BUT I'VE NEVER BEEN INVOLVED IN RESEARCH...

No problem. It's easy. It's just talking in a group or a private interview.

HOW DO I GET MORE INFO?

Call this number. Leave a message. I will call back and explain.

852-6212

Research Study **852-6212**	**Research Study** **852-6212**	**Research Study** **852-6212**	**Research Study** **852-6212**

APPENDIX G

DIMENSIONAL ANALYSIS MATRICES FOR INDIVIDUAL STRATEGIES

Dimensional Analysis Matrix for:

Risk Avoiding Strategies with Minor Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions	Strategies selected	N/A social risk w/ peers
Minor	Inexperienced in independent living		Avoiding Strategies	N/A social risk re job N/A intervention for condition
	Separated from family and friends	Cues from peers regarding the health condition		N/A individual health risks
	Living in a small community	Social Barriers		N/A peer health risks
	Transient residents	Cues from peers regarding the local formal health services		
	Have low paying jobs	SP attitude towards local social/health care providers		
		Employers attitude towards taking time from work		
		Logistical barriers		
		Time constraints		
		Financial constraints		
		Visibility of local formal health services		
		Poor understanding of how to access local formal services		

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact

Dimensional Analysis Matrix for:

Risk Avoiding Strategies with Stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions	Strategies selected	N/A social risk w/ peers
Stigmatizing	Inexperienced in independent living		Avoiding Strategies	N/A social risk re job
	Separated from family and friends	Cues from peers regarding the health condition		N/A intervention for condition
	Living in a small community	Social Barriers		– individual health risks
	Transient residents	Cues from peers regarding the local formal health services		- peer health risks
	Have low paying jobs	SP attitude towards local social/health care providers		
		Employers attitude towards taking time from work		
		Logistical barriers		
		Time constraints		
		Financial constraints		
		Visibility of local formal health services		
		Poor understanding of how to access local formal services		

N/A	Not applicable
-	Unfavorable impact
+	Favorable impact
±	Equivocal impact

Dimensional Analysis Matrix for:

Risk Avoiding Strategies with Unquestionable Non-stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions	Not applicable for conditions with this attribute	
Unquestionable non-stigmatizing	Inexperienced in independent living			
	Separated from family and friends	Cues from peers regarding the health condition		
	Living in a small community	Social Barriers		
	Transient residents	Cues from peers regarding the local formal health services		
	Have low paying jobs	SP attitude towards local social/health care providers		
		Employers attitude towards taking time from work		
		Logistical barriers		
		Time constraints		
		Financial constraints		
		Visibility of local formal health services		
		Poor understanding of how to access local formal services		

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact

Dimensional Analysis Matrix for:

Risk Minimizing Strategies with Minor Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions	Strategies selected	N/A social risk w/ peers
Minor	Inexperienced in independent living		Minimizing Strategies	N/A social risk re job
	Separated from family and friends	Cues from peers regarding the health condition		N/A intervention for condition
	Living in a small community	Social Barriers Cues from peers regarding the local formal health services		± individual health risks
	Transient residents			± peer health risks
	Have low paying jobs	SP attitude towards local social/health care providers		
		Employers attitude towards taking time from work		
		Logistical barriers		
		Time constraints		
		Financial constraints		
		Visibility of local formal health services		
		Poor understanding of how to access local formal services		

N/A	Not applicable
-	Unfavorable impact
+	Favorable impact
±	Equivocal impact

Dimensional Analysis Matrix for:

Risk Minimizing Strategies with Stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition Stigmatizing	Adolescents and young adults Inexperienced in independent living Separated from family and friends Living in a small community Transient residents Have low paying jobs	Fear of confidentiality and anonymity transgressions Cues from peers regarding the health condition Social Barriers Cues from peers regarding the local formal health services SP attitude towards local social/health care providers Employers attitude towards taking time from work Logistical barriers Time constraints Financial constraints Visibility of local formal health services Poor understanding of how to access local formal services	Strategies selected Minimizing Strategies	N/A social risk w/ peers N/A social risk re job ± intervention for condition – individual health risks - peer health risks

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact

Dimensional Analysis Matrix for:

Risk Minimizing Strategies with Unquestionable Non-stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition	Adolescents and young adults	Fear of confidentiality and anonymity transgressions	Not applicable for conditions with this attribute	
Unquestionable non-stigmatizing	Inexperienced in independent living			
	Separated from family and friends	Cues from peers regarding the health condition		
	Living in a small community	Social Barriers		
	Transient residents	Cues from peers regarding the local formal health services		
	Have low paying jobs	SP attitude towards local social/health care providers		
		Employers attitude towards taking time from work		
		Logistical barriers		
		Time constraints		
		Financial constraints		
		Visibility of local formal health services		
		Poor understanding of how to access local formal services		

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact

Dimensional Analysis Matrix for:

Risk Embracing Strategies with Minor Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition Minor	Adolescents and young adults Inexperienced in independent living Separated from family and friends Living in a small community Transient residents Have low paying jobs	Fear of confidentiality and anonymity transgressions Cues from peers regarding the health condition Social Barriers Cues from peers regarding the local formal health services SP attitude towards local social/health care providers Employers attitude towards taking time from work Logistical barriers Time constraints Financial constraints Visibility of local formal health services Poor understanding of how to access local formal services	Strategies selected Embracing Strategies	N/A social risk w/ peers N/A social risk re job N/A intervention for condition +/± individual health risks +/± peer health risks

N/A	Not applicable
-	Unfavorable impact
+	Favorable impact
±	Equivocal impact

Dimensional Analysis Matrix for:

Dimensional Analysis Matrix for:

Risk Embracing Strategies with Stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition Stigmatizing	Adolescents and young adults Inexperienced in independent living Separated from family and friends Living in a small community Transient residents Have low paying jobs	Fear of confidentiality and anonymity transgressions Cues from peers regarding the health condition Social Barriers Cues from peers regarding the local formal health services SP attitude towards local social/health care providers Employers attitude towards taking time from work Logistical barriers Time constraints Financial constraints Visibility of local formal health services Poor understanding of how to access local formal services	Strategies selected Embracing Strategies	- social risk w/ peers - social risk re job + intervention for condition + individual health risks + peer health risks

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact

Dimensional Analysis Matrix for:

Risk Embracing Strategies with Unquestionable Non-stigmatizing Conditions

Attributes	Context	Condition	Action	Consequences
Nature of the health condition Unquestionable non-stigmatizing	Adolescents and young adults Inexperienced in independent living Separated from family and friends Living in a small community Transient residents Have low paying jobs	Fear of confidentiality and anonymity transgressions Cues from peers regarding the health condition Social Barriers Cues from peers regarding the local formal health services SP attitude towards local social/health care providers Employers attitude towards taking time from work Logistical barriers Time constraints Financial constraints Visibility of local formal health services Poor understanding of how to access local formal services	Strategies selected Embracing Strategies	N/A social risk w/ peers N/A social risk re job + intervention for condition + individual health risks + peer health risks

N/A Not applicable
- Unfavorable impact
+ Favorable impact
± Equivocal impact